

**EXPERIENCES AND PERCEPTIONS OF CLIENTS ATTENDING A SOUTH AFRICAN  
UNIVERSITY SEXUAL HEALTH CLINIC**

By  
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## **DECLARATION**

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## ABSTRACT

The sexual health clinic at Stellenbosch University is attended by staff members and students. Yet, limited evidence exists regarding the views and expectations of the clients on service delivery at the sexual health clinic.

The aim of the study was to explore the experiences and perceptions of clients attending the sexual health services offered at the campus health clinic. The following objectives were set:

- To explore the experiences and perceptions of the clients attending the sexual health service on service delivery.
- To identify the needs of the clients attending the sexual health service

A descriptive qualitative approach was applied utilizing in-depth interviews. A sample of n=15 was drawn through purposive sampling and data saturation was achieved with the sample. Since the researcher is employed as a registered professional nurse at the clinic, data collection was completed by a researcher not affiliated to the university. Data was analyzed utilizing an interpretive approach. All applicable ethical principles such as anonymity, confidentiality and privacy were taken into consideration. The validity of the findings was enhanced through efforts to attain credibility, transferability, dependability and conformability.

The findings of the study revealed that accessibility of the clinic is influenced by the geographical location of the clinic and that marketing and awareness of services requires attention. Other themes that emerged were operational hours, waiting period, building relationships, consultations and financial implications.

Key words: Sexual health, experiences, perceptions, students, staff

## OPSOMMING

Die seksuele gesondheidskliniek by Universiteit Stellenbosch word deur personeel en studente besoek. Daar is egter min bewyse oor die sieninge en verwagtinge van die kliente aangaande dienslewering by die seksuele gesondheidskliniek.

Die doel van die studie was om die ervarings en sienings van kliente wat die seksuele gesondheidsdienste bywoon, aangebied deur die seksuele gesondheidskliniek, te ondersoek.

Die volgende doelwitte was gestel:

- Om die ervarings en sienings van kliente aangaande dienslewering by die seksuele gesondheidskliniek te ondersoek.
- Om die behoeftes van die kliente wat die seksuele gesondheidsdienste bywoon, te identifiseer.

'n Beskrywende kwalitatiewe benadering was toegepas deur van in-diepte onderhoude gebruik te maak. 'n Steekproef van  $n=15$  was deur doelgerigte steekproefneming verkry en data-versadiging was met die steekproef bereik. Siende die navorser as 'n geregistreerde professionele verpleegster by die kliniek in-diens is, was data-versameling deur 'n navorser wat nie aan die universiteit verbonde is nie, voltooi. Data was deur 'n interpreterende benadering geanaliseer. Alle verwante etiese beginsels soos anonimiteit, vertroulikheid en privaatheid was in berekening geneem. Die geldigheid van die bevindinge was versterk deur pogings om geloofwaardigheid, oordraagbaarheid, betroubaarheid en bevestigbaarheid te verkry.

Die bevindinge van die studie het getoon dat die toeganklikheid van die kliniek beïnvloed word deur die geografiese ligging van die kliniek en dat bemaking en die bewusmaking van dienste aandag benodig. Ander temas wat na vore gekom het, is operasionele tye, wagperiodes, verhoudings, konsultasies en finansiële implikasies.

Sleutelwoorde: Seksuele gesondheid, ervarings, sienings, studente, personeel

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## ABBREVIATIONS

CHS	Campus health service
HIV	Human Immunodeficiency Virus
RPN	Registered professional nurse
SU	University of Stellenbosch
STIs	Sexually transmitted illnesses
WHO	World Health Organization

## **CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY**

### **1.1 INTRODUCTION**

The HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) pandemic has impacted on the attrition rate of undergraduate students and staff of higher education institutions in Africa. Statistics that demonstrate the severity of the situation are minimal since recordkeeping that relates to HIV/AIDS among university staff and students are seemingly absent (Katahoire, 2004:5-14). Institutions of higher education can however play a vital role in sexual health promotion and prevention. The World Association for Sexual Health (2008:6) recommends that health services, such as a university campus clinic, should provide convenient services to attend to sexual health needs. These services should include: effective prevention of Sexually Transmitted Illnesses (STIs); the provision of contraceptives; voluntary counseling and testing. Moreover, comprehensive care and treatment of HIV/AIDS and other STIs should be supported with culturally appropriate, comprehensive, rights-based and gender sensitive sexuality education programs. These aspects are equally essential to the sexual health of students and staff by encouraging a fully informed and autonomous decision-making client.

However, the quality of service delivery at university campus clinics requires proven evidence, that quality care has been delivered and that the service meets the needs of the clients. Subsequently, the evaluation of the standard of service delivery, as well as the needs of the clients at these clinics, should receive ongoing attention.

### **1.2 BACKGROUND AND RATIONALE**

The Campus Health Service (CHS) of Stellenbosch University (SU) is a health facility for students and staff and is situated on the university grounds.

The facility provides services for acute medicine, health promotion and preventative medicine, exercise medicine and occupational health. The acute medicine component has a subdivision that focuses on sexual health (Stellenbosch University, Campus Health Service, 2010:np). The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social well-being related to sexuality (WHO, 2012:np).

The provision of sexual health services on campus is of value since the university population consists of diverse cultures with different beliefs and perceptions regarding sexual health. At the commencement of this study in 2011, 2 868 personnel with permanent appointments were employed at SU, of which 1 334 (47%) were male and 1 534 (53%) were female.

Statistics according to race reflect that 1 722 (60%) were white, 985 (34%) were colored, 133 (5%) Indian and 28 (1%) were black. The statistics show that 28 193 students were enrolled in 2011, of which 13 876 were male and 14 317 were female. Statistics according to race for students enrolled in 2011, reflect that 8 915 were white, 4 454 were colored, 42 33 were black and 591 were Indian students (Stellenbosch University, Statistical profile, Core Statistics, 2007-2011).

The Campus Health Service statistics for 2011 reflect that 35 clients attended the clinic for STIs, 5 clients were diagnosed HIV positive and emergency contraceptive pills were dispensed to 42 clients (Stellenbosch University, Campus Health Service Statistics, 2011). Emergency contraceptive pills prevent pregnancy after unprotected intercourse. It is a method that inhibits ovulation, decelerates the transportation of an egg or sperm and impairs the implantation of a fertilized egg (Miller, 2011:683).

At the University of Cape Town, 4 996 clients of which the majority were students were tested for HIV in 2011, 3 124 by HIV testing drives; 628 by mobile unit; 1 146 by drop-in and 98 at the Student Wellness Services. Only 20 students tested HIV positive (University of Cape Town, Report to Council, 2012:8). No statistics could be found on the prescription of emergency contraceptive pills or medication dispensed for STIs. It is however advertised on the university website which pharmacies could be attended in order to acquire the emergency contraceptive pill (University of Cape Town, 2014).

At the University of KwaZulu-Natal, the prevalence of HIV amongst students is 2.4%; academic staff 1.0%; administrative 5.5% and service staff 16.3% (Higher Education South Africa, 2008:29-30). However, the HIV prevalence amongst students at South African universities is 3.4%, which is well below the national average (University World News, 2010:np).

International studies regarding sexual behavior among university students confirm the prevalence of relatively high figures of HIV, STI and the use of emergency contraceptives among students (Trieu, Bratton & Marshak, 2011:744-747; Hollub, Reese, Herbenick, Hensel & Middlestadt, 2011:708-711). Yet, the available statistics on the prevalence of STI, HIV and emergency contraceptives among the population at Stellenbosch University are seemingly low if compared to the total population of staff and students, which in 2011 were 31 061. The figures however appear to be in congruence with the findings of Katahoire (2004:3-13). Katahoire (2004:3-13) avers that these figures in Sub-Saharan Africa are low due to poor recordkeeping by the university administrators and that students and staff seek assistance



outside the campus structures due to fear of stigma. Recordkeeping at SU campus health clinic up to 2011 consisted of individual files for each client with handwritten notes made by either the nurse or the doctor who attended the client. Electronic recordkeeping commenced at the beginning of 2012. Yet, information pertaining to stigma and how the clients view the service provided by the campus health clinic does not exist as no previous surveys that relate to service delivery were conducted at the CHS of SU.

However, Downing-Matibag and Geisinger (2009:1206) recommend the development of mandatory and nationwide sexual risk prevention programs that provide incoming students with accurate information regarding STIs and how to protect themselves. Furthermore, the authors advocate that prevention programs and resources need to be available and promoted to students from their first to last day on campus and at a variety of venues.

To improve sexual health behaviors and perceptions, sexual health services should attempt to educate and provide the clients with accurate information regarding sexual health (Shapiro & Ray, 2007:67-68). The SU CHS does not provide preventative programs, educational sessions or peer group teaching. Clients who attend the services are educated on an individual basis regarding preventative measures.

In addition, Ramsaran-Fowder (2004:428) purports that it is important to clients that health care quality be evaluated. The author emphasizes that client satisfaction and service quality are critical issues in the health care sector. The latter is confirmed by Strawderman and Koubek (2008:460) who postulate that the client is the only person that can judge service quality and that client perceptions are a key factor in the judgment of service quality.

In total 28 193 students were enrolled in 2011 and 2 868 personnel with permanent appointments were employed at SU (Stellenbosch University Statistical Profile, Core Statistics, 2007-2011). Yet, no baseline information was available that reflects the viewpoints of clients attending the sexual health clinic at SU. Since the majority of the population is students, meaning young adults, the current study was valuable as it focused on how the students experience the services rendered at the sexual health clinic.

A study completed by Lees (2011:25) demonstrated that the input by consumers has become essential in the planning, delivery and evaluation of health care. Lees (2011:25) also reports a growing acknowledgement of the value of the clients' viewpoint.

### **1.3 PROBLEM STATEMENT**

As mentioned in the rationale, the presence of STI, HIV and the use of emergency contraceptives are seemingly low among the clients attending the sexual health clinic. Recordkeeping in relation to statistics of STI, HIV and the use of emergency contraceptives at the CHS of SU were however done manually and not electronically until 2011. No previous studies were conducted that relates to the quality of sexual health service rendered at the clinic. Therefore substantial evidence that relates to the quality of sexual health service from the clients' viewpoint was absent. Through exploring the experiences and perceptions of the students and staff that use the sexual health clinic, the clients were granted the opportunity to verbalize their opinions.

### **1.4 SIGNIFICANCE OF THE STUDY**

The findings of the study provided information on the quality of service delivery at the sexual health clinic. Information regarding the experiences and perceptions verbalized by clients attending the sexual health clinic during data collection, assisted with the identification of the needs/shortcomings in service delivery. These needs will serve as a baseline for improvement regarding the desired quality of service delivery.

### **1.5 RESEARCH QUESTION**

The study was guided by the following research question: What are the experiences and perceptions of clients (students and staff) attending the sexual health services offered at the campus health clinic?

### **1.6 GOAL**

The goal of the study was to explore the experiences and perceptions of clients attending the sexual health services offered at the campus health clinic.

### **1.7 OBJECTIVES**

The specific objectives are:

- To explore the experiences and perceptions of the clients attending the sexual health service on service delivery.
- To identify the needs of the clients attending the sexual health service.

### **1.8 RESEARCH METHODOLOGY**

A brief overview of the research methodology applied in this study is rendered in the current chapter and a complete report follows in chapter 3.

### **1.8.1 Approach and design**

A descriptive qualitative approach utilizing in depth interviews was followed to explore the experiences and perceptions of the clients attending the sexual health services offered at the campus health clinic. In addition the accompanying analysis assisted to identify the needs of clients.

### **1.8.2 Population and sampling**

The population consisted of all students and staff who attended the sexual health services offered at the main campus health clinic in Stellenbosch. Purposive sampling was used to select fifteen key participants. It allowed the researcher to select the sample based on the knowledge that each individual participant has of the phenomena under study as advised by Brink, Van der Walt and Van Rensburg (2012:141).

#### **1.8.2.1 Criteria**

- All staff members, irrespective of biographical data, who have attended the clinic at the SU main campus between March 2013 and September 2013
- All students, irrespective of biographical data, enrolled at the SU main campus who have attended the clinic between March 2013 and September 2013
- All staff members and students who have accessed the CHS at the SU main campus more than once

### **1.8.3 Instrumentation**

Instrumentation consisted of in depth interviews and a semi-structured interview guide. The interview guide was based on the objectives of the study. The interview method provides an opportunity to get to know people more intimately so that the interviewer can understand how the participants really think and feel (Terre Blanche, Durrheim & Painter, 2006:297). The semi-structured interview guide allows the exploration of particular interesting issues that emerge in the interview. It also enables and the participant to provide a fuller picture about the phenomenon under study (De Vos De Vos, Strydom, Fouche & Delport, 2011:351).

The interview guide contained open-ended questions that are based on the objectives of the study (see Appendix A). De Vos *et al.* (2011:352) mention that open ended questions should be asked to allow the participant to express themselves freely.

### **1.8.4 Pilot Interview**

A pilot interview was conducted with one participant who met the criteria of the study. The pilot interview uncovered no difficulties.

### **1.8.5 Data collection**

Data collection was completed by a fieldworker who received training on the techniques and principles of interviewing. The fieldworker received training on the conduction of interviews utilizing Rogerian principles. Rogerian principles concerns the technique of reflection which includes showing/demonstrating unconditional positive regard towards the interviewee (Boeree 2007:np). In addition, the fieldworker attended communication skills courses and assisted in previous qualitative interviews. Fifteen in depth interviews were conducted at a venue comfortable for the participants. All interviews were tape recorded.

### **1.8.6 Validity/Truthfulness**

Validity or truthfulness of the findings was assured by the criteria of credibility, transferability, dependability and conformability as explained by De Vos *et al.* (2011:419-420).

The fieldworker demonstrated sufficient knowledge for the correct operation of the tape recorders and received training on interviewing skills.

### **1.8.7 Data analysis**

Data analysis was done according to the approach described by Terre Blanche *et al.* (2006:322-326). The principal of bracketing was applied to ensure that the researchers' personal concepts and beliefs regarding service delivery at SU CHS did not interfere with the findings of the study. The interviews were transcribed by a professional transcriber.

### **1.8.8 Ethical considerations**

Ethical approval to conduct the study was obtained from the Health Research Ethical Committee at Stellenbosch University. Institutional approval was obtained from the management of SU.

Participation in the study was voluntary. Written informed consent was obtained from each participant. Privacy, confidentiality and anonymity of all participants were ensured at all times. All written notes and transcripts of the interviews are kept in a locked safe for five years.

## **1.9 DEFINITIONS OF TERMS**

**Client** - For the purpose of this study the term client refers to the students and staff of Stellenbosch University who attend the main CHS.

**Emergency contraception** or post-coital contraception refers to methods of contraception that can be used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure (such as failure to use contraceptive pills daily or torn condoms), rape or coerced sex (World Health Organization, Emergency Contraception Fact Sheet, 2012:np).

**Experience** is a practical involvement in an activity to have knowledge and skill gained over time (Oxford English Mini Dictionary, 2007:195).

**Family Planning** allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility (World Health Organization, Family Planning, 2013:np).

**Human Immunodeficiency Virus (HIV)** is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker and the person becomes more susceptible to infections. The most advanced stage of HIV infection is Acquired Immunodeficiency Syndrome (AIDS) (World Health Organization, HIV/AIDS, 2013:np).

**Perception** as described by George (2010:198) is a process in which data obtained through the senses and from memory are organized, interpreted and transformed.

**Quality** refers to characteristics of and the pursuit of excellence (Huber, 2010:526).

**Quality Improvement** is an overarching organizational strategy to ensure accountability of employees, incorporating evidence-based health care quality indicators, to continuously improve care delivered to various populations (Huber, 2010:526).

**Sexual Health** is a state of physical, mental and social well-being in relation to sexuality (World Health Organization, Sexual and Reproductive Health, 2013:np).

**Sexually Transmitted Infections (STIs)** are infections that are spread primarily through person-to-person sexual contact (World Health Organization, Sexually Transmitted Infections, 2012:np).

**Young people** refer to both adolescents and youth, meaning those between 10 and 24 years of age (National Contraception Policy Guidelines, Government of South Africa 2001:32).

## **1.10 STUDY OUTLAY**

### **Chapter 1: Scientific Foundation of the Study**

In chapter 1 the background and rationale of the study are portrayed. A brief overview of the research question, objectives, methodology, definitions of terms and the study layout are provided in this chapter.

### **Chapter 2: Literature Review**

In chapter 2 a discussion of the existing literature concerning the topic is provided.

### **Chapter 3: Research Methodology**

Chapter 3 contains an in depth description of the research design and methodology utilized for the study.

### **Chapter 4: Data analysis and Interpretation**

The information obtained during data collection are analyzed and interpreted in chapter 4.

### **Chapter 5: Discussions and Recommendations**

Chapter 5 consists of a discussion of the findings of the study and recommendations that are made based on the scientific evidence obtained in the study.

## **1.11 SUMMARY**

This chapter contains a discussion on the sexual health services rendered at a campus health clinic and its value in combating HIV/AIDS and STIs as well as the availability of emergency contraceptives.

The discussion showed that although statistics regarding students and staff attending the sexual health services are relatively low, risky sexual behavior remains a concern amongst young adults. Fear of stigmatization and discrimination could be factors that influence client attendance of sexual health services. Therefore, service delivery at the campus health clinic was explored via in depth interviews and qualitative analysis.

The following chapter presents the literature review pertaining to service delivery and sexual health as it relates to young adults specifically in a university community.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 INTRODUCTION

The review of the literature entails a presentation of existing literature pertaining to service delivery and sexual health as it relates to young adults specifically in a university community. De Vos *et al.* (2011:109) declare that a literature review is conducted to establish the theoretical framework for the study. Consequently, it indicates where the study fits into broader debates and justifies the significance of the research project. Therefore, this chapter presents findings from the review of relevant literature.

### 2.2 THE PROCESS OF THE LITERATURE

The review contains current, historical and probable future sexual and reproductive health related issues among university communities in the context of service delivery at campus health clinics. A combination of international and South African literature was reviewed and service delivery appeared to be of significant importance.

The review commenced before the proposal for the study was completed. Upon completion of data analysis, it became evident that the findings of the study relate to aspects such as accessibility, affordability and quality assurance of the facility. However, these aspects were not thoroughly addressed in the initial review. Therefore, after completion of the data analysis the review was strengthened and adapted to provide information that aligned with the findings of the study.

The collection of information was retrieved from text books, journals, electronic sources, dissertations as well as electronic data bases such as PubMed and ProQuest medical libraries. Except for legislation that was used to support the current study, all resources were no more than 10 years old. Literature was gathered over a period of 18 months.

### 2.3 FINDINGS FROM THE LITERATURE

The literature review is discussed under the following headings:

- Factors influencing the attendance of reproductive health services
  - Accessibility
  - Awareness
  - Marketing and advertising
  - Affordability
  - Human resources – adequate staffing
  - Attitudes

- Knowledge of health care providers
- Trust in health care providers
- Consultation with health care providers
- Stigma
- Health education
- Referral to campus health services
- Socio-economic development
- Value of client perceptions and experiences of a service
- Quality, quality assurance and service delivery
  - Risk management
- Definition of sexual health and young people
- Sexual health and universities globally
- Sexual health in South Africa
  - Legislation
  - Research regarding sexual behavior of young people in South Africa
- Human Immunodeficiency Virus (HIV)
- Sexually transmitted illnesses (STIs)
- Emergency contraceptives
- Diverse cultures and sexual health

### **2.3.1 FACTORS INFLUENCING THE UTILIZATION OF REPRODUCTIVE HEALTH SERVICES**

#### **2.3.1.1 Accessibility of service**

Accessibility of a service relates to the geographical location of the service and how convenient it is for clients to attend the service in terms of time and distance (Muller, Bezuidenhout & Jooste, 2006:492).

The geographic context plays a critical role in health outcomes because it is associated with primary care utilization of services. Increased distances to health care facilities negatively reflect poor accessibility of service due to long travel distances (Yao, Murray, Agadjanian & Hayford, 2012:601-607). However, the authors purport that despite geographical proximities, it was evident that clients were willing to travel long distances in order to receive contraceptive methods. Yet, they were not keen to travel in order to attend the service for HIV testing and counseling.



The above statement of Yao *et al.* (2012:601-607) is supported by Kamau (2006:1-271) who avers that the lack of decentralized health facilities cause disparities in the provision of health care. For many young people the location of the service prevents them from attending the service, especially if sexual health services are rendered within maternal health program clinics. In addition, it is imperative that they have correct information regarding the location of the service, as they are embarrassed and uncomfortable to request directions to sexual health services. Hence, they are reluctant to seek professional health care assistance. Likewise, young people may delay seeking sexual health service when they have incorrect information regarding the location of a service or their eligibility for health care Kamau (2006:1-271). Therefore, adequate transportation to a long distance facility poses a challenge to attend sexual health services.

#### **2.3.1.2 Awareness**

Awareness of sexual health information and sexual health services influences the attendance of the service. Lebese, Maputle, Ramathuba and Khoza (2013:7) found in their study that the main source of sexual health information was through peers. The majority of participants revealed that they became aware of sexual health related information and services via close friends. The authors identified that one of the reasons for not attending services include unawareness of where to seek assistance. Therefore, marketing and advertising of sexual health services could be beneficial.

#### **2.3.1.3 Marketing and advertising**

According to MacDonald, Cairns, Angus and Stead (2012:1-2) social marketing is the application of marketing techniques for the planning, implementation and evaluation of programs in an attempt to influence pro-social voluntary behavior change in order to improve personal and society welfare. The authors purport that a genuine social marketing intervention contains a number of key elements such as consumer orientation, a mutually beneficial exchange and long-term planning. The social marketer seeks to build a relationship with target consumers over time. Marketing tools such as pamphlets, billboards and magazines are beneficial strategies to promote sexual health services as proposed by Singh and Begum (2010:80).

#### **2.3.1.4 Affordability**

Clients are often faced with unaffordable cash payments which are made at the time of illness, depending on the clients' ability to pay. Fees are charged by both the hospital and the primary health care providers. High cash payments are associated with exclusion from health facilities altogether, ignoring early disease and results in higher levels of poor health. One of Africa's biggest challenges is health care financing, whilst increased government spending

on health directed to primary care is essential (Logie, Rowson, Mugisha & Mcpake, 2010:1-3). Consequently high costs hinder attendance to health care services, especially by poor and vulnerable persons in the public health system (Pieterse, 2010: 236).

#### **2.3.1.5 Human resources-adequate staffing**

Many countries are facing a shortage of qualified health care providers. South Africa particularly is facing challenges regarding the shortage of health care providers and the high rate of HIV infections. According to the South African Nursing Council, in 2013, 260 698 nursing health care providers were responsible to care for a population of 52 982 000. In the Western Cape the ratio of qualified nurse to patient is 196:1. It is evident that the country lacks adequate staffing in comparison to patient population (South African Nursing Council, Geographical Distribution, 2013:np). Therefore, Kamua (2006:223) purports that health care provider shortages hinder service attendance. Inadequate staffing ultimately results in excessive waiting periods and referrals to other facilities.

Alli, Maharaj and Vawda (2013:np) purport that health care provider shortages therefore, contribute to health care providers encountering heavy patient loads. Due to the lack of providers, limited time is spent on consultation with clients. Moreover, the long waiting queues forces providers to complete a consultation with a patient as quickly as possible. The situation contributes to missed opportunities to provide important information and health education to clients. In addition, providers are overworked, frustrated and are perceived by clients as incompetent and unfriendly (Alli *et al.*, 2013:np).

Consequently, health care provider shortages could hinder attendance to services, resulting in a limited understanding of sexual health information and a possible increase in sexual health risks.

#### **2.3.1.6 Attitudes**

Clients are often uncomfortable discussing sensitive topics with health care providers. The discomfort experienced by clients of sexual health services could be ascribed to the manner in which they are approached and treated by health care providers. Clients attending sexual health clinics are sometimes treated with disrespect and denied services. These factors are discouraging to clients and could lead to a lack of basic information and lack of sexual health knowledge (Tilahun, Mengisti, Egata & Reda, 2012:2-7). The authors purport that negative attitudes of health care providers are a significant barrier to service utilization and hampers efforts by government to reduce STIs and unwanted pregnancies (Tilahun *et al.*, 2012:2-7).

The provision of youth-friendly services may aid in changing health care providers attitudes towards young people who seek sexual health assistance (Mbeba, Mkuye, Magembe, Yotham, Mellah & Mkuwa, 2012:4). One of the most significant reasons for young people not attending sexual health services is the fear of embarrassment and judgmental attitudes of health workers (Feleke, Koye, Demssie & Mengesha, 2013:9; Alli *et al.*, 2013:np). Consequently, as these factors limit attendance to sexual health services, attention has been drawn to the development of youth-friendly and more acceptable sexual health services.

#### **2.3.1.7 Knowledge of health care provider**

It is essential that health care providers are supportive and knowledgeable in treating HIV positive people, STIs, unintended pregnancies and support an environment free from stigma and discrimination. Clients seek information, explanations and support during sexual health consultations. However, health care providers often lack adequate knowledge regarding basic concepts and skills to support clients with sexual health needs. In addition, health care providers are often faced with guidelines from different sources which contain conflicting information. Therefore, comprehensive and appropriate training for health care providers is necessary to meet the requirements and expectations of clients. Yet, health care providers should not only have skills for clinical care, counseling and knowledge of bio-medical aspects to meet sexual and reproductive health needs of clients. Training for health care providers should include knowledge, skills, rights, gender and ethics related aspects. Such training enhances their ability to comfortably discuss sensitive sexual health issues and could therefore reduce adverse sexual health outcomes (Bharat & Mahendra, 2007:93-112; Ford, Barnes, Rompalo & Hook, 2013:96-100).

#### **2.3.1.8 Trust in health care provider**

Meiberg, Bos, Onya and Schaalma (2008:53) aver that people do not always trust health care workers not to inform others about their health status. Therefore, it is important to guarantee anonymity and confidentiality. However, according to the authors HIV reporting by name in the United States had no effect on the use of testing and counseling services. Yet, the issue of anonymity and confidentiality is very important in South Africa and prevents people from attending services for testing and counseling.

In addition, Meiberg *et al.* (2008:53) found that people tend to mistrust the skills of health care providers to competently perform HIV testing. Health care providers may also lack competence in practicing standardized treatment protocols and counseling procedures which may result in client dissatisfaction and confusion. Clients are often deprived of a better understanding regarding sexual health issues, which results in negative outcomes such as

unintended pregnancies, STIs and HIV infection. Consequently, clients lose trust in providers (Bharat & Mahendra, 96-99; Ford *et al.*, 2013:96-100).

#### **2.3.1.9 Consultations with health care providers**

The utilization of sexual health services are influenced by the prospect of a client consulting with a health care provider of the same gender as the client. Often female patients prefer to consult with health care providers of the same gender. The physical and emotional health assessment of clients is subjected to the health care provider obtaining the sexual history of clients. However, because of the sensitivity of sexual health issues, clients are often unwilling to disclose important information that may hinder accurate treatment options. Therefore, it should be taken into consideration that females are more comfortable discussing sexual health issues with female providers (Politi, Clark, Armstrong, McGarry & Sciamanna, 2009: 511-515).

Kamau (2006:122-220) avers that female clients also show a preference to consult with younger health care providers. In addition, health care providers noted that clients desired to consult with the same provider each time they attend the service. According to Alli *et al.* (2013:np) health care workers cited that young clients do not always speak openly to providers about health problems due to the age and gender of the provider. Providers relate that clients perceive them as mother or father figures since they are much older than the clients. Culturally, the clients may therefore, be reluctant to discuss sexual issues since it could be perceived as disrespectful.

#### **2.3.1.10 Stigma**

In addition, the HIV/AIDS epidemic is often described as an epidemic of ignorance, fear and denial leading to stigmatization and discrimination against people living with the disease (Meiberg *et al.*, 2008:50). According to a report of the Joint United Nations Program on HIV/AIDS (2010:np), HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV and/or associated with HIV. Stigma refers to any attribute or characteristic of a person that is deeply discrediting. The main causes of stigma are ignorance, threat and contagiousness. Religious factors and some culturally-specific factors seem to be related to stigmatization of HIV/AIDS in Sub-Saharan countries. Moreover, since HIV/AIDS is a disease that can be prevented and treated, attitudes towards HIV/AIDS could change and stigma and discrimination could be reduced if ignorance, fear and denial are diminished. Therefore, the providers of sexual health services should ensure that these services are without elements of stigma, discrimination or bias (Meiberg *et al.*, 2008:50-53; Vermeer, Bos, Mbwambo, Kaaya & Schaalma, 2009:135-140).

#### **2.3.1.11 Health education**

According to the National Contraception Guidelines young people in South Africa have limited knowledge of reproductive functioning leading to confusion and misperceptions regarding contraception (National Contraception Guidelines, Republic of South Africa, 2001:10-11).

Students' failure to accurately assess their own or their partners' susceptibility to STIs was also ascribed to limited knowledge on sexual health. It was found that individuals tend to only engage in preventative behaviors once they perceive that they are susceptible to an adverse health outcome (Downing-Matibag & Geisinger, 2009:1204).

An important contributing factor for the health and well-being of the youth is access to effective sexual health education. Sexual health education is based on the principle that it should be accessible to everyone, should be provided in an appropriate, culturally sensitive manner that is respectful of a clients' right to make informed decisions regarding sexual health. Subsequently, appropriate education provides an opportunity to develop the knowledge, personal insight, motivation and behavioral skills that are consistent with individual personal values and choices. The positive outcome of sexual health education is that youth often extend sexual activities to an older age and prevent unwanted pregnancies, STIs and HIV infection. In order to ensure that youth are adequately equipped with the information and skills to protect their sexual health, it is imperative that schools, in cooperation with health care providers, play a major role in sexual health education and promotion. The commencement of sexual health education in school-based programs is an important strategy to provide youth with accurate information that would influence sexual health outcomes (Mckay & Bissell, 2010:1-8).

#### **2.3.1.12 Referral to campus health services**

Fletcher *et al.* (2007:490) conducted a study where students reported to have general knowledge about on-campus health service availability. However, despite acknowledgement of these services, students were unable to provide ratings for these services. The authors' state that this is most likely attributable to the fact that students failed to utilize these services since students reported not being referred to the campus health services, which is disconcerting. Sexual health care providers often require counseling skills, but frequently lack the skills to refer clients.

Kamau (2006:1) relates that despite the fact that young people face sexual health risks, health care providers persist to perceive them as healthy individuals who require minimal

health services. Therefore, young people are often not considered a high priority when resources are allocated, hence poor utilization of the service. However, Tilahun *et al.* (2012:2) purport that the demand for sexual and reproductive health services for young people is increasing in developing countries. Yet, there is limited evidence on the provision of the service, its effectiveness and the role of the different providers involved. Therefore, integrated services delivered through the healthcare system are identified as one of the most effective ways to deliver sexual health services.

#### **2.3.1.13 Socio-economic development**

According to the National Contraception Policy Guidelines (Republic of South Africa, 2001:11) low contraceptive use is linked to poor socio-economic development and greater contraceptive use is associated with urbanization. Moreover, 73% of people in rural areas in South Africa are impoverished and do not always have access to health services. Women with higher levels of education also tend to use reproductive health services more than women with less education. Consequently, improving women's educational and economic positions could create improved utilization of contraception and their control over sexual and reproductive matters (Republic of South Africa, 2001:11).

Sub-Saharan Africa constitutes 70% of the world's poorest people. Accordingly, this poor population struggle for basic needs and lacks money, assets and skills. Men are often obliged to leave their families to work in mines in another province. Therefore, some men tend to engage in promiscuity that increases the risk of HIV transmission, divorce and reduced monetary remittance. In addition, some women and children indulge in prostitution as a means of income to survive. Hence, unprotected sexual encounters place them at risk to contract and spread HIV and STIs. Single mothers who are unable to cope with the household frequently encourage their daughters to drop out of school and enter marriage as a strategy for economic survival. However, teenage marriages merely continue the poverty cycle. Consequently, the factors that contribute to poverty such as low levels of education, skills, poor health and productivity persist. Therefore, the outcomes of poverty are associated with high risk sexual behavior such as polygamy, teenage marriages and sexual trade (Mbirimtengerenji, 2007:605-617; Tladi, 2006:369-381).

It is important to assess the factors influencing the attendance of sexual health services in order to increase attendance and therefore, reduce negative consequences associated with sexual health.

## **2.4 VALUE OF CLIENT PERCEPTIONS AND EXPERIENCES OF A SERVICE**

Lees (2010:26) states that there has been a growing acknowledgement of the value of the patients' viewpoint during the planning, delivery and evaluation phases of health care. Therefore, organizations should create circumstances, reinforce behaviors and manage interactions that allow clients and families to have an experience grounded in their own viewpoint. Clients' perceptions are mostly influenced by organizational actions and management. It is however, impossible to expect the same experience for all clients as their perceptions are influenced by individual characteristics such as beliefs, values and cultural backgrounds (Wolf, 2012:np).

Women on the other hand, tend to regard quality of care and the way in which people are treated as the most important aspect of contraceptive service provision. Women also commonly request that health care providers should be more understanding and accessible for explanation and counseling (Republic of South Africa, 2001:10).

Therefore, the management of healthcare organizations, as well as campus health clinics should consider the input and values of their clients.

## **2.5 QUALITY, QUALITY ASSURANCE AND SERVICE DELIVERY**

Quality refers to characteristics of and the pursuit of excellence. Health care quality is the degree to which health care services increase the likelihood of desired health outcomes and whether it is consistent with current professional knowledge (Huber, 2010:526). Booyens (2008:269) avers that patient satisfaction with health care is an important quality and outcome indicator.

Quality assurance on the other hand, is a formal, systematic exercise of problem identification, designing activities to overcome the problems, initiation of follow-up steps to eliminate new problems and the implementation of corrective steps (Booyens, 2008:251).

It is fundamental to a quality assurance program that services provided by a facility are continuously assessed. Quality assessment depends entirely on the monitoring of service utilization and the processes applied for the delivery of reproductive health services. Hence, if quality assessment is built into the routine of monitoring services, providers are more likely to be committed to the process of quality service delivery (Republic of South Africa, 2007:1-22; Singh, 2006:1-82).

Achieving quality health care services include measuring the gaps between service standards and actual practice. In the attempt to close the identified gaps, facilities should focus on areas such as the service environment. It is therefore, important to ensure regular maintenance of the building and amenities as the physical environment of a facility influences patients' perceptions and experiences of the service rendered. Women attend sexual and reproductive health services for issues that are personal and sensitive and expect to be consulted in an area that is private and hygienic (Republic of South Africa, 2007:1-22; Singh, 2006:1-82).

In an attempt to provide quality service to clients, service providers should ensure adequate communication and listening skills, provide adequate information regarding contraception and consider the clients language and dialect. It is important to enable clients to make informed decisions. The opportunity to make an informed decision enhances feelings of satisfaction and control over their health. Therefore, providers should address socio-economic determinants of health behavior and offer alternative choices to clients without using medical jargon. The aforementioned elements are factors that could influence comprehensive care and client satisfaction (Singh, 2006:1-82).

In addition, since each individual has unique needs and expectations that seek satisfaction, each individual will perceive satisfaction differently. Different service personnel will deliver the same service in different ways. Services can also be different each time an individual used the service and are highly people and behavior dependent. An effective service meets the customers' expectations, demands and needs. Consequently, it achieves its objectives for service delivery. Behavior, limitations and abilities of service providers are important factors that affect service delivery (Strawderman & Koubek, 2008:456). Customers base their opinion on past experiences, the service process and service delivery.

Standards have been developed with the aim of enabling people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare. These standards entail sexual health service networks; promotion of sexual health; empowerment and involvement of clients using the services; identification of sexual health needs; improving access to services; prompt and rapid detection and management of STIs; provision and advice on contraception; pregnancy testing and support; provision of abortion services and protection of confidential sexual health information. Consequently, these standards attempt to ensure quality care (Medical Foundation for AIDS and Sexual Health, 2005:6).



The United Nations Population Fund reports that improving quality of care can be a cost-effective means of achieving the ultimate goal of better reproductive and sexual health services (United Nations Population Fund, nd:np). Improving quality of care is part of health reform processes that are under way in many countries. Often insufficient attention is given to the specific ways in which quality of care applies to reproductive and sexual health services.

Batho Pele is a South African political initiative that was developed to serve as an acceptable policy and legislative framework regarding service delivery in the public service. In order to improve quality service to the public, Batho Pele strives to ensure that all citizens have equal right to attend services, are given accurate information regarding services and are treated with courtesy and respect (Republic of South Africa, 1997:3-35). Therefore, according to Muller, *et al.* (2006:492), quality service delivery in health care is associated with accessibility, appropriateness, environmental safety, timeliness of care and effectiveness.

### **2.5.1 Risk management**

Risk management forms an integral component of an institutions quality improvement and health care safety program. Through these programs risks are evaluated and controlled in order to reduce or prevent future loss to the institution. Risk management according to Huber (2010:526) is an interdisciplinary process designed to protect the financial assets of the organization and to maintain high quality medical care.

Risk management requires an ongoing assessment of potential risks at all levels in the institution. Subsequently the risks are aggregated to facilitate priority setting and improve decision making. The identification, assessment and management of the risks do not merely focus on minimizing risks. It supports activities that promote improvement in order to achieve significant outcomes with acceptable results, costs and risks (Berg, 2010:79-95).

In addition, incident reports, which are the factual accounting of an incident, are utilized as a tool for ongoing risk identification and reporting to ensure that all facts regarding the incident are recorded. Incident reporting ensures the opportunity for managers to investigate, collate, analyze and identify potential risks immediately that assists in providing quality services (Huber, 2010:556-557).

It is important that sexual health services endeavor to reduce health risks to their clients. In an attempt to reduce these risks, the service should have sufficient equipment and stock available to manage all clients. An unprocured supply of contraceptives and emergency

contraceptive pills could lead to health risks such as unsafe abortions and unplanned pregnancies. In addition, health care workers who provide sexual health services could increase the health risks of clients. These risks include incompetence with the technique or procedure to obtain a cervical smear or prescribing contraceptive methods without obtaining sufficient knowledge of the clients' medical history (WHO, 2011:np).

Therefore, it is imperative that risk management policies be in place to ensure the safety of service providers and clients who attend the sexual health services on campus.

## **2.6 DEFINITION OF SEXUAL HEALTH AND YOUNG PEOPLE**

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching (Republic of South Africa, 2001:36).

The National Contraception Policy Guidelines (Republic of South Africa, 2001:32) propose that the term “young people” covers both adolescents and youth, meaning those between 10 and 24 years of age. It is in this period where physical, psychological and social maturing from childhood to adulthood occurs. Consequently, it is a period wherein sexual and reproductive health education has a substantial impact on their actions concerning relationships.

## **2.7 SEXUAL HEALTH AND UNIVERSITIES GLOBALLY**

Limited evidence exists concerning the health of young adults, most likely attributable to the fact that young adults perceive themselves to be insusceptible to infirmity (Fletcher *et al.*, 2007:482). This lack of information extends into higher education sectors that have venues for dispensing health information and education to many young adults. Therefore, Fletcher *et al.* (2007:482) purport that information concerning student health problems on universities are inadequate.

Downing-Matibag and Geisinger (2009:1207) relate that attending college has always been an important period of transition for young adults, as it involves moving away from the family nest and living in a peer-dominated culture. The young adult student should then assume primary responsibility for managing their lives, from their classes and career trajectories to their interpersonal and sexual relationships. Rittenour and Booth-Butterfield (2006:57) relate concerns about sexual activity among young adults and how risky sexual conduct could negatively affect their lives. According to the authors, partner and peer communication about sexual risk taking and precautions has proven to be effective in the prevention of sexual risk behaviors (Rittenour & Booth-Butterfield, 2006:59). They suggest that by integrating

knowledge about how college students support and learn from each other, strides can be made to decrease students' high risk behavior that leads to unwanted pregnancies.

Alcohol consumption played a key role in risky sexual behavior among university students in the United Kingdom (Chanakira, O' Cathain, Goyder & Freeman, 2014:1055) According to the authors, students were more likely to engage in risky sexual behavior in the university environment as opposed to other social contexts. This could be due to peer expectations and that they are living independently away from home without parental or community guidance.

It was found that African American females enrolled at colleges in the United States of America may be at greater risk of contracting HIV as opposed to females not attending college. The students tend to engage in risky sexual behavior such as inconsistent condom use and multiple sexual partners. Despite the students' knowledge regarding HIV transmission, prevention and the consequences of risky sexual behavior, safe sexual encounters are still not practiced (Paxton, Villarreal & Hall, 2013:1-2).

In addition, at a university in Australia, students consume higher levels of alcohol than the broader community that puts them at a higher risk for irresponsible sexual behavior, especially among female students. The authors emphasized that alcohol abuse had a definite association with unwanted pregnancies, rape, unprotected sex and STIs (Gilchrist, Smith, Magee & Ones, 2012:35-43).

Prior reviews of youth intervention studies in both developed and developing countries, suggest an important role for school-based interventions in increasing young people's knowledge of sexuality, reproductive health and HIV prevention (Harrison *et al.*, 2010:2). The prevalence of HIV among people aged 15 to 49 is reported as 17.2-18.3% for 2009 (WHO, 2011:np).

Students are the largest population group at universities and their well-being is of great importance. In order to provide holistic health care to the campus community, their needs have to be assessed and informational sessions have to be provided in the effort to maintain good health statuses. The health status of both students and health care provider determines the success of one another (Ricks, Strumpher & van Rooyen, 2010:1-7).

## 2.8 SEXUAL HEALTH IN SOUTH AFRICA

Sexual health in South Africa is enhanced through the following three policies:

- The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in further Education and Training Institutions (Republic of South Africa, 1999)
- National Education Policy Act 27 of 1996 (Republic of South Africa, 1996)
- National Contraception Policy Guidelines (Republic of South Africa, 2001)

The National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in further Education and Training Institutions (Republic of South Africa, 1999) was developed to control and thus prevent the spread of HIV in South Africa. The policy provides a framework for the development of provincial and school policies and strategic plans to curb HIV/AIDS.

In addition to the above-mentioned policy, the National Education Policy Act 27 of 1996 (Republic of South Africa, 1996) state that continuing life-skills and HIV/AIDS education programs are to be implemented at all schools and institutions for all learners, students, educators and other staff members. The curriculum should include the provision of HIV/AIDS information and development of life-skills necessary for the prevention of HIV transmission.

The National Contraception Policy Guidelines were developed to enhance contraceptive provision in South Africa and to identify gaps that need to be addressed. According to the guidelines, the state is the main provider of contraceptive services in South Africa. Furthermore, the guidelines report that among young people, knowledge of reproductive function is generally poor and that there is considerable confusion and misperceptions regarding contraception (Republic of South Africa, 2001:11).

The Department of Health in South Africa supports the family planning program to improve the health and status of women and children, while limiting the rate of population growth (Maharaj & Rogan, 2007:8). Women who attained Grade 10 and beyond, were more than twice as likely to use contraception compared with women with less education (Maharaj & Rogan, 2007:27). The authors purport that these findings may be attributed to the fact that schools increase awareness and educate pupils regarding safe sex practices and contraceptive use. Thaver and Leao (2006:87) support the above mentioned by stating that the variety of different life skills curricula implemented by South African schools and institutions focuses largely on HIV/AIDS awareness. According to the authors, the curricula have positively affected the students' knowledge and awareness but does not adequately

meet the goals of the national policy, which is to promote healthy behavior and positive attitudes.

The National Contraception Policy Guidelines (Republic of South Africa, 2001:21) communicates their objective to increase public knowledge of clients' contraceptive rights, methods and services. Strategies to achieve this objective include the development of appropriate information, education and communication messages, materials and programs about contraception for multimedia dissemination. According to the guidelines service providers and educators should be trained to educate the public on contraception utilization. It is also reflected in the guidelines that research be conducted to monitor and evaluate information, education and communication initiatives related to contraception. Ultimately the findings of the proposed research could assist in the development of future initiatives.

### **2.8.1 Legislation**

The South African reproductive health policies and laws are among the most progressive and comprehensive in the world as it provides recognition of sexual and reproductive rights (Republic of South Africa, 2009:i). Various policies and regulations related to maintaining sexual health in South Africa are discussed in the following paragraphs.

#### *I. Contraception*

The term contraception or family planning was explained in Chapter 1, Section 1.9. According to the WHO's Family Planning Fact Sheet (2012:np), there are different methods of contraception such as the combined oral contraceptive pills, progestogen only pills, progestogen only injections, monthly combined injections, implants, intra-uterine devices, the lactational amenorrhea method, male and female condoms, male and female sterilization and emergency contraception. Parental or partner permission is not required should a female decide to commence contraceptive methods.

#### *II. Emergency Contraception*

According to a Fact Sheet on Emergency Contraception by the WHO (2012:np), emergency contraception, or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first few days after intercourse. It is intended for emergency use following unprotected intercourse, contraceptive failure (such as failure to use contraceptive pills daily or torn condoms), rape or coerced sex. The term emergency contraception is supported by the explanation in chapter 1, section 1.2. The emergency contraceptive pill can be obtained at any primary health care clinic within 72 hours of the sexual encounter (Republic of South Africa, 2012: np).

### *III. Sexually Transmitted Infections (STIs)*

Sexually Transmitted Infections (STIs) are infections that are spread primarily through person-to-person sexual contact (WHO, 2012: np). According to the Sexual Transmitted Infections policy (Department of Health, Republic of South Africa, 2011:np), treatment for STIs is freely available at no charge at all primary health care facilities.

### *IV. Termination of Pregnancy*

The Choice on Termination of Pregnancy Act 92 of 1996 (Republic of South Africa, 1996) stipulates that any woman, irrespective of age can request a legal abortion for an unwanted pregnancy. The Act promotes reproductive rights and extends freedom of choice by affording every woman the right to have an early, safe and legal termination of pregnancy according to her individual beliefs.

According to The Termination of Pregnancy policy, Department of Health (Republic of South Africa 2013:np) women or teenagers who are pregnant do not require consent of parents or partners for the termination of a pregnancy. Women should, however, be provided with pre and post termination of pregnancy counseling.

### *V. Cervical Cancer Screening*

The Provincial Policy and Guidelines, Cervical Cancer Screening and Colposcopy Services, Department of Health (Republic of South Africa, 2009:4) state that cervical smears are available for all women, aged 30 years and older. Women are allowed a lifetime total of three free cervical smears taken at 10 year intervals. In addition, follow up treatment for abnormal tests are provided free of charge.

## **2.8.2 Research regarding sexual behavior of young people in South Africa**

Irrespective of government strategies to improve sexual health among the population, risky sexual behavior is still present. The risky behavior includes unprotected sex, early sexual debut, inconsistent condom use and multiple partners. In addition, substance dependence has further exacerbated the underlying problems associated with the high levels of sexual risk behavior (Chersich, Rees, Scorgie & Martin, 2009:2).

Nonetheless the provision of reproductive health programs at an early stage are important since young people become sexually active while they are enrolled in school (Madeni *et al.*, 2011:2). Madeni *et al.* (2011:2) relate that many young people who become sexually active at an early age lack fundamentally important knowledge and skills. A lack of sexual education in the school curriculum, meaning inadequate implementation of the National

Education Policy Act 27 of 1996 (see 2.3.3), could also be a factor. Other reasons cited for the perceived lack of sexual health knowledge are the degree or quality of communication with parents and the efficacy of the reproductive health program. However, Madeni *et al.* (2011:11) found that peer education was reported to support young people in their decision-making during adolescence because friends tend to be the main source of information about sexual practices and peer pressure.

## 2.9 HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV is a retrovirus that infects cells of the immune system, destroying or impairing their function. The most advanced stage of HIV infection is Acquired Immunodeficiency Syndrome abbreviated AIDS (WHO, 2013:np). According to a report of the WHO on HIV/AIDS in the Global Health Observatory (2013:np), almost 70 million people have been infected with HIV and approximately 35 million people have died of AIDS since the beginning of the epidemic. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (WHO, Global Health Observatory, HIV/AIDS, 2013: np).

A report by the Higher Education HIV/AIDS Program on HIV prevalence at South African higher education institutions (2010:np), stated that Stellenbosch University (SU) was one of the first of the 23 South African higher education institutions to participate in a national survey on HIV prevalence and risk assessment among both students and staff. The survey involved a total of 25 000 staff members and students at various institutions in South Africa. The findings of the survey are displayed in Table 2.1 below.

**Table 2.1 Students and academics: HIV prevalence rate (%) by region and population group**

Group	National	Western Cape	Eastern Cape	Free State	Gauteng N West & Limpopo	KwaZulu-Natal
<b>Students</b>						
African	5.6	3.1	8.4	8.7	3.1	8.7
Coloured	0.8	0.3	0.5	0.0	3.2	0.0
Indian	0.3	0.0	0.0	0.0	0.0	0.5
White	0.3	0.0	0.0	0.0	0.5	0.0
<b>Academic staff</b>						
African	5.9	2.6	7.6	0.0	4.3	9.6
Coloured	0.0	0.0	0.0	0.0	0.0	0.0
Indian	0.0	0.0	0.0	0.0	0.0	0.0
White	0.1	0.0	0.0	0.0	0.2	0.0

It is clear that according to Table 2.1 above, the prevalence of HIV was the highest among African students in KwaZulu-Natal and the Free State. In addition, HIV prevalence among African academic staff was the highest in KwaZulu-Natal and the Eastern Cape. The lowest HIV prevalence for students prevailed in the Western Cape. However, the lowest prevalence of HIV among academic staff appeared to be in the Free State Province.

A study conducted by Mphana (2010:89) in Lesotho, revealed a need for education that relates to HIV transmission, myths, stigma and behavior change. Mphana (2010:89) found that students have adequate knowledge about HIV/AIDS prevention and care. However, irrespective of whether students have adequate knowledge on HIV/AIDS prevention, the implementation of programs that would improve insight and skills, thus, enhancing changes in attitude and behavior, remains a challenge. Furthermore, the HIV/AIDS pandemic has increased the awareness of other STIs. In recent years, STIs have occurred mostly among young people, with the highest reported rates found among those aged 15-24 years (Hogue, 2011:157; Maseko, 2011:np).

## **2.10 SEXUAL TRANSMITTED ILLNESSES (STIs)**

Maseko (2011:np) suggests that a targeted effort is necessary to inform youth, especially female adolescents, about STI symptoms and signs as well as consequences of untreated infections. Moreover, prevention activities for STIs and HIV should be enhanced and STI screening should be integrated in primary care consultations to increase the number of adolescents diagnosed and treated for STIs (Maseko, 2011:np).

Hoque (2011:157) reports young adults are continuously at higher risk of STIs, HIV infections and unwanted pregnancies than the general public. The higher measure of vulnerability is due to higher levels of sexual experimentation and unsafe sexual practices among young adults. It is therefore, necessary to modify social, cultural, educational activities as well as campaigns to improve students' understanding of the consequences of unsafe sexual behavior.

## **2.11 EMERGENCY CONTRACEPTIVES**

Emergency contraception in South Africa has only recently been made available to women, directly from a pharmacist without a prescription (Maharaj & Rogan, 2007:2). Furthermore, Maharaj and Rogan (2007:36) state that currently an enabling environment, without a lack of client knowledge of contraception, paucity of educational material and literature availability in health facilities, to increased usage of emergency contraception is currently unavailable in South Africa. The authors purport that there are still several gaps in the literature around the



informed choice of South African women for emergency contraceptives. These gaps include issues in the differences in the provision and availability of emergency contraception as well as the attitudes and awareness of providers regarding guidelines and training protocols (Maharaj & Rogan, 2007:39).

Furthermore, Kitshoff (2010:86) reports that substantial uncertainties and misperceptions about contraception still exist among university students who are generally supposed to have a higher awareness of contraception. These misperceptions concern knowledge of the time limit, usage and efficiency of emergency contraception. The lack of knowledge regarding how and when emergency contraception should be used could put students at risk of an unplanned pregnancy.

Byamugisha, Mirembe, Faxelid and Gemzell-Danielsson (2006:198) reveal that the awareness of emergency contraception among university students in Uganda is relatively low. Less than half of the students had never heard of it. Ikeme, Ezegwui and Uzodimma (2005:491-493), state that more or less sixty percent of female undergraduates in Nigeria had heard about emergency contraception. It can therefore be deduced that African universities should introduce or increase awareness programmes regarding contraceptives.

## **2.12 DIVERSE CULTURES AND SEXUAL HEALTH**

Universities and campus health services are faced with the reality that many of the enrolled students are from diverse cultures and that students have different health statuses. The shared experience of different cultures, backgrounds and ancestry could lead to differences in health behavior such as beliefs and perceptions of personal health behavior (Lartey, Mishra, Odonwodo, Chitalu & Chafatelli, 2009:131). Therefore, students might not prioritize health and development above adherence to cultural or religious beliefs and moral codes (World Association for Sexual Health, 2008:25).

Irrespective of culture, Buhi, Marhefka and Hoban (2010:337) found a difference in sexual practices along racial lines in the United States of America. The authors found that White students are more experienced in oral and anal sex than Black students. White students are, however, less likely to use condoms for oral, anal and vaginal sex. White students are less likely to undergo HIV-testing compared to black students. Black students however, had more sexual partners, lower use of hormonal contraceptives as well as higher rates of adverse sexual health outcomes such as STIs and unwanted pregnancies. White students however, have greater risk for oropharyngeal cancer than black students since oral Human Papilloma Virus can enter the mouth during oral sex and cause cancer (Buhi *et al.*, 2010:343).

Therefore, sexual health programs and research studies should consider differences that relate to racial and ethnic groups as advised by Rittenour and Booth-Butterfield (2006:64).

### **2.13 SUMMARY**

The attendance of sexual health services are influenced by accessibility, affordability, awareness of the service, human resources, attitudes of the health care providers, health care provider development, socio-economic development and referrals. Providers of sexual health care should consider issues related to quality assurance and service delivery such as client satisfaction and client participation in service delivery. However, sexual health services providers should consider general client education in an effort to increase the utilization of reproductive health services.

The literature review has shown that university students engage in sexual behavior that seems to be risky. Consequently, the students might contract HIV/AIDS and STIs. The risky sexual behavior could be attributed to misperceptions regarding contraceptive methods. Likewise, cultural, religious and socio-economic factors impacts decision making regarding contraceptive methods. The South African government has launched various legislation and policies to inform young adults in this regard, to support them to be sexually responsible. Educators are guided by various policies to provide appropriate sexual health education in order to minimize the spread of HIV/AIDS. Despite the implementation of legislation to decrease the prevalence of HIV/AIDS, South Africans are still faced with a high incidence of the disease. It is pertinent that stigmatization still has an influence on the attendance of reproductive health services, specifically issues related to HIV/AIDS.

Chapter 3 presents a discussion of the research methodology used to explore the experiences and perceptions of clients attending a South African University sexual health clinic.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

The previous chapters furnished a description of the background to the study. It also contains a comprehensive literature review regarding sexual health among young adults and service delivery at a university sexual health clinic, both globally and nationally.

The goal of this chapter is to delineate the research methodology applied to determine the experiences and perceptions of clients attending a South African university sexual health clinic. The research methodology according to Mouton (2005:56) focuses on the research process and the tools and procedures to be used. It commences with specific tasks e.g. data collection and sampling. Furthermore, it focuses on the individual (not linear) steps in the research process and the most “objective” (unbiased) procedures to be employed (Mouton, 2005:56). This chapter introduces a detailed comprehensive description of the specific research method used in the current research study. Therefore, it outlines the aim, objectives, research question, design, study population, sampling, the measurement instruments and data collection including the analysis of the research study.

### **3.2 AIM OF THE STUDY**

The aim of the study was to explore the experiences and perceptions of clients (students and staff) attending the sexual health services offered at Stellenbosch University, campus health service (SU CHS).

### **3.3 OBJECTIVES**

The objectives set for the study were:

- To explore the experiences and perceptions of the clients attending the sexual health services at SU CHS regarding service delivery
- To identify the needs of the clients attending the sexual health service

### **3.4 RESEARCH METHODOLOGY**

#### **3.4.1 Research design**

A research design is a blueprint for maximizing control over factors that could interfere with a study's desired outcome (Grove, Burns & Gray, 2013:43). The current study followed a descriptive design with a qualitative approach. Brink *et al.*, (2012:121) explain that qualitative research methods focus on the qualitative aspects of meaning, experience and understanding. These methods are used to study human experience from the viewpoint of the research participants in the context in which it occurs.

A descriptive design was used as it concerns assembling more information about the phenomena under study. In the current study a description is provided on issues that relate to service delivery at the sexual health clinic. A qualitative approach was followed as it allowed the researcher to identify and elaborate on the participant's description of their experiences and perceptions of the sexual health clinic under study. The approach provided an opportunity to gain more information, understand and interpret their viewpoint and needs regarding service delivery.

### **3.4.2 Population**

The term population is defined by Grove *et al.* (2013:44) as all the elements that meet certain criteria for inclusion in a study. Brink *et al.* (2012:131) confirm that a population is the entire group of persons that meets the criteria that is of interest to the researcher. The population for the study consisted of all clients (N=1146) who used the sexual health services provided between March 2013 and September 2013 at the main campus in Stellenbosch.

### **3.4.3 Recruitment**

The services offered at the clinic include, contraceptive services, STI treatment, HIV testing and services for various conditions related to sexual health. Counseling sessions are embedded in each consultation.

The researcher is employed as a registered professional nurse at the sexual health clinic where the study was conducted and has access to the clients' personal and medical information. The Protection of Personal Information Bill (Republic of South Africa, 2009:7-8), requires that the researcher obtains permission from each potential participant indicating that they are willing to be contacted for research purposes. Therefore, the electronic information regarding clients who had attended the services at the clinic was not used for recruitment purposes.

Instead the researcher approached participants who met the sample criteria after their sexual health consultation and requested permission from them that they be contacted for research purposes. The inclusion criteria relate to clients who had attended the clinic more than once and who had attended the clinic for either STI treatment, HIV counseling and testing or for contraceptives. These categories were included as they constituted the range of services that are available at the clinic. The researcher confirmed with the prospective participants that they indeed meet the inclusion criteria before continuing the process. The potential participants were requested to complete a form whereby they consented to be contacted for research purposes. The permission form to be contacted was then completed by the

participants after a short introduction to the study. The clients, who consented that they be contacted, provided details such as their names and telephone numbers. This document was not the informed consent document to participate in the study, but merely permission that they be contacted for research purposes.

A total of 21 clients who attended the sexual health services consented to be contacted. The 21 clients constituted the total accessible population.

#### **3.4.4 Sampling**

A sample according to Burns *et al.* (2013:44) is a subset of the population that is selected for a particular study. Brink *et al.* (2012:131-132) confirm that the sample is a part of a larger set selected by the researcher to participate in a research study. The sample in the current study was selected by means of purposive sampling. Purposive sampling is based on the judgment of the researcher regarding participants that are representative of the study phenomenon and are especially knowledgeable about the question at hand (Brink *et al.*, 2012:141).

The researcher purposively selected participants that met the inclusion criteria. With purposive sampling, the researcher deliberately seeks typical and divergent data (De Vos *et al.*, 2011:392). The search for data was guided by processes that would provide rich detail to maximize the range of specific information that could be obtained from and about the context. In addition, Skinner (2007:323) avers that when using purposive sampling the researcher deliberately chooses respondents in order to ensure that the sample covers the full range of possible characteristics of interest. For the purpose of this study, the researcher endeavored to ensure that the final sample included participants who had used either or more than one of the range of services available at the clinic.

Considering the range of services available at the clinic and the range of participants to be included, it was decided to recruit at least fifteen (n=15) participants. The final sample however, depended on the occurrence of data saturation.

The first five participants' viewpoints regarding service delivery varied. Information obtained were of a general nature and not distinct. It was evident that the participants who are staff members had resembling viewpoints regarding service delivery at the sexual health clinic and little in-depth information was obtained. Yet, information obtained from participants who were students differed. Consequently, the researcher recruited more participants in order to retrieve a more descriptive elaboration regarding their range of experiences. After the tenth interview it was clear that information began to follow a distinct trend. The final sample

consisted of fifteen clients (n=15). The clients provided rich information on their experiences at the sexual health clinic. Data saturation was obtained with fifteen clients. Data saturation is reached when additional sampling yields no new information, only redundancy of data already collected (Brink *et al.*, 2012:144).

#### **3.4.5 Instrumentation**

The instrumentation consisted of open ended questions using a semi-structured interview guide. The interview method provides an opportunity to get to know people more intimately so that the interviewer can understand how the participants really think and feel (Terre Blanche *et al.*, 2006:297). The semi-structured interview guide, according to De Vos *et al.* (2011:351), allows for the exploration of particularly interesting issues that emerge in the interview and the participant is probed to provide a fuller picture.

The interview guide contained open-ended questions that are based on the objectives of the study (see Appendix A). De Vos *et al.* (2011:352) mention that open ended questions should be asked to allow the participant to express themselves freely.

#### **3.4.6 Pilot Interview**

Brink *et al.* (2012:174) relate that a pilot interview is done to determine whether possible imperfections in the instrument exist, such as ambiguous instructions or wording. An interview with one participant was conducted at the institution under study to test the interview guide. The participant met the criteria of the study and revealed no difficulties.

### **3.5 VALIDITY**

Validity is concerned with the accuracy and truthfulness of scientific findings (Brink *et al.*, 2012:127). Validity was enhanced through efforts to attain credibility, transferability, dependability and conformability.

#### **3.5.1 Credibility/Authenticity**

Credibility according to Terre Blanche *et al.* (2006:90) refers to the extent to which causal conclusions can be drawn. To ensure credibility an assessment was done to ascertain if there was a match between participants' views and the researchers' reconstruction and representation of it. Subsequently, the transcripts as well as the final themes were presented to the participants for verification.

### **3.5.2 Transferability**

Transferability, also referred to as generalizability, relates to the extent to which the interpretative account can be applied to other contexts than the one being researched (Terre Blanche *et al.*, 2006:381). The possibility that the findings be transferable or generalized to other settings can be enhanced by providing detailed information on the research procedure that was used (De Vos *et al.*, 2011:420). Therefore detailed descriptions and a thick database are provided on the research process, for example population and sampling as well as data collection and analysis.

### **3.5.3 Dependability**

Dependability is the degree to which the findings of a study are repeatable (Terre Blanche *et al.*, 2006:92). As advised by De Vos *et al.* (2011:420), an assessment was done by an enquiry auditor to determine how well the research was conducted and whether the research process was logical, well documented and audited. Dependability is achieved through robust descriptions to indicate how certain actions and opinions are rooted in, and developed out of contextual interaction (Terre Blanche *et al.*, 2006:93). Therefore, the methods used in the study were provided with rich and detailed descriptions to convince others that the findings did indeed occur as related by the researcher. The findings of the study were clarified and verified by the researcher and fieldworker.

### **3.5.4 Conformability**

Conformability is the degree to which the findings can be confirmed by others (De Vos *et al.*, 2011:421). Therefore, the interviews were transcribed verbatim. The resembling themes were reviewed by the supervisor of the study and where divergence existed, the researcher and supervisor reviewed the transcripts until concordance was reached.

## **3.6 ETHICAL CONSIDERATIONS**

Ethical approval to conduct the study was obtained from the Health Research Ethical Committee at Stellenbosch University. Approval was requested and obtained from the senior director of the CHS SU as well as the management of Stellenbosch University.

### **3.6.1 The principle of respect for human dignity**

According to Polit and Beck (2010:140), respect for human dignity involves the participant's right to self-determination which means participants have the freedom to control their own activities. Therefore, participation in the study was voluntary and participants were informed that they have the right to withdraw from the study at any stage without penalty.

### **3.6.2 The principle of beneficence**

Polit and Beck (2013:80-96) purport that beneficence implies that participants should be protected from physical and psychological harm and exploitation. Provision was made for participants to be referred to the university psychological services should they become distressed during the interviews. However, this was not necessary for any of the participants.

### **3.6.3 The principle of confidentiality and anonymity**

Confidentiality was secured by protecting all data gathered within the scope of the project from being divulged or made available to any other unauthorized person as advised by Brink *et al.* (2012:38). Only the researcher and supervisors involved had access to the data. Participants were assured that information obtained will not identify them personally. Therefore, participants were not referred to by name during the interviews. In addition, the transcribed interviews were nameless and labeled according to codes, for example, interview 1, interview 2. Furthermore, there were no risks involved to participants' confidentiality and anonymity as the interviews were personally transcribed by the researcher. All written notes and transcripts of the interviews will be kept in a locked safe for at least five years.

## **3.7 DATA COLLECTION**

Before data collection commenced the researcher contacted the potential participants who consented to be contacted telephonically to schedule an appointment suitable to them. A short introduction of what the research study entailed was verbally presented to the participants again to ensure that they understood what the study is about. Voluntary consent to participate in the research study was completed by each participant during this consultation.

Data collection commenced in August 2013 and completed early September 2013. In order to prevent bias a fieldworker not affiliated to the university conducted the individual interviews. The fieldworker has a master's degree and was previously involved with data collection in qualitative research and received training on interviewing skills by the supervisor involved in the study.

Interviews were conducted at SU campus health service boardroom. The participants regarded the boardroom as a comfortable venue. Each interview lasted 30 minutes and less. Interviews were conducted in English or Afrikaans, depending on the preferences of the participant. Participants were informed that the fieldworker is not affiliated to the university. The fieldworker commenced each interview with a short summary of what the study is about as advised by Terre Blanche *et al.* (2006:29). Each interview commenced with an open



ended question, "Tell me about your experiences with the campus sexual health service?" In order to ensure that information given by participants was understood correctly, the interviewer used communication skills such as summarizing, reflecting and clarifying information received from the participants.

A tape recorder was used to audio tape all interviews. De Vos *et al.* (2011:359) mention that a tape recorder allows a much fuller record than notes taken during the interview and permits undivided attention to be granted to the participant. Two tape recorders, an electrical and a battery operated tape recorder were available to ensure data capturing. The researcher trained the interviewer to ensure sufficient knowledge of the operation of the tape recorders and made provision for extra storage capacity on the device including sufficient batteries.

During the data collection phase preliminary analysis was done which involved data analysis in the field, meaning that as the interview proceeded, conclusions could be made regarding the dominant or less dominant trends as advised by De Vos *et al.* (2011:405).

### **3.8 DATA ANALYSIS**

According to De Vos *et al.* (2011:397) qualitative analysis transforms data into findings, involves reducing the volume of raw data and identifies significant patterns. Therefore, this process initiates order, structure and meaning to the mass of data collected.

The interviews were transcribed by the researcher within 24 hours of each interview. Field notes were typed and organized, which enhanced the researcher's immersion in the data as advised by De Vos *et al.* (2011:408). An interpretive approach was used during the data analysis process. The latter implies that interpretations are made of what has been seen, heard and understood (De Vos *et al.*, 2011:65). As advised by Terre Blanche *et al.* (2006:322), the principle of bracketing was applied during the process of data analysis to ensure that the researchers' personal concepts and beliefs regarding service delivery at SU CHS did not influence the results of the study. All personal preconceived experiences and opinions were set aside with the intention of engaging in the new information obtained from the participants. Data analysis was done according to the process of the five analytic steps described by Terre Blanche *et al.* (2006:322-326):

#### **3.8.1 Familiarization and immersion**

This step entails the researcher immersing themselves within the field notes and the interview transcripts. On completion of this step the researcher should be familiar with the data and have a sense of what the data entails (Terre Blanche *et al.*, 2006:323). To achieve

this, the transcripts were read repeatedly and the recordings listened to repeatedly. Notes were made while the researcher listened to the recordings and read the transcripts. The intense interaction with the data took place, in order to create themes and categories and to develop ideas and theories about the topic being studied.

### **3.8.2 Inducing themes**

This process includes the steps to identify and conceptualize phrases that represent the phenomenon as well as the induction of themes. These concepts were grouped and named according to similarity that represents the research topic. As advised by Terre Blanche *et al.* (2006:323) instead of using abstract theoretical language, the researcher attempted to use the language of the interviewees to label the categories. While the researcher remained focused on the intention of the study, main themes and subthemes were generated and labeled.

### **3.8.3 Coding**

This step entails marking different sections of the data as being instances of, or relevant to, one or more of the themes (Terre Blanche *et al.*, 2006:324-326). This was done by marking different sections of the data that are relevant to the themes. Baring in mind that codes should not be regarded as final and unchanging, the computer cut and paste function was used to break up and move text around into labeled meaningful pieces. Similar information was grouped together and categorized under specific themes and sub themes. This gave the researcher a fresh view on the data and permitted an opportunity to compare sections that appeared to belong to each other.

### **3.8.4 Elaboration**

At this stage themes are revised. Themes were explored more closely to capture the finer nuances of meaning not captured in the previous steps. As advised by Terre Blanche *et al.* (2006:326), continuous coding and elaboration took place until no new insights emerged.

### **3.8.5 Interpretation and checking**

In this final step interpretations were put together in a written account of the phenomenon being studied using thematic categories. The interpretations were assessed to identify contradictions and relationships between themes and corrected weak points in the interpretations as proposed by Terre Blanche *et al.* (2006:326). In addition the authors advised that it is important that the researcher indicate how personal involvement in the phenomenon may have blurred the way data was collected or analyzed. In order to consider the interpretations from a fresh perspective, Terre Blanche *et al.* (2006: 326) advises that the

interpretations be discussed with other people who are knowledgeable about the topic and even those who know less. Therefore, the interpretations were reviewed by the fieldworker, supervisor and co-supervisor of the study.

According to Terre Blanche (2006:371-372) all research studies can be further exploited for new meanings. However, a study draws to a conclusion when:

- New thoughts do not add anything new to the understanding that was already developed
- All questions originally set out are answered and adequately represents the data collected
- Interpretations are critically reviewed and no uncertainty regarding the interpretations exist
- New data confirms the account instead of causing disintegration
- Opinions are shared with other researchers and provide answers to their questions

This stage is also referred to as saturation which refers to the condition of an interpretive account where the account is richly fed by the material that has been collected (Terre Blanche *et al.*, 2006:372). Therefore, on completion of this stage it was decided that the information received is indeed sufficient, as it enabled the researcher to answer the research question.

### **3.9 SUMMARY**

This chapter entails a report regarding the research methodology applied in the study. A comprehensive description of the goal, objectives, research design, population and sampling, including ethical considerations are presented in this chapter. A detailed account of the data collection and analysis processes are provided. The interpretations of the findings are provided in chapter 4.

## CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

### 4.1 INTRODUCTION

This chapter provides a detailed outlay of the findings of the study. Data obtained through interviews were analyzed to explore the experiences and perceptions of clients attending the sexual health clinic at the SU main campus.

The researcher transcribed the interviews verbatim, meaning the exact words and phrases of the participants were transcribed. In order to ensure confidentiality and anonymity the transcribed interviews were nameless and labeled according to codes, for example, interview 1, interview 2.

Inductive reasoning was applied to construct themes. De Vos *et al.* (2011:49) state that inductive reasoning does not commence with pre-established truths or assumptions but rather with an observation of a general theoretical explanation. The authors purport that new thoughts are added, which is not necessarily contained in the premise. It is thus a bottom-up approach.

Data analysis was conducted as described by the approach of Terre Blanche *et al.* (2006:322-326). This approach was described in chapter 3, Section 3.8. Data obtained is portrayed in two sections. Section A, relates to the biographical data of participants and Section B presents the themes obtained from the data collected.

### 4.2 SECTION A: BIOGRAPHICAL DATA

#### 4.2.1 Age

The ages of the students who participated ranged between 20 and 25. The ages of staff members that participated ranged between 25 and 45.

#### 4.2.2 Gender

The total number of participants included in the study were fifteen (N=15) and consisted of one (n=1) male and fourteen (n=14) females. Upon recruitment of participants, males were more reluctant than females to participate or talk about sexual health issues.

#### 4.2.3 University status

The majority of the participants in the study were students. This is due to the large student enrolments. The Stellenbosch university statistical profile reflects that 28 156 students were enrolled in 2013 and a total 3 085 staff members were permanently employed (Stellenbosch

University, Statistical profile, Core Statistics, 2013). Therefore five (n=5) of participants were staff members and ten (n=10) were students.

#### **4.2.4 Duration on campus**

Except for the two (n=2) first year students, all participants have been enrolled or employed at the university for more than 3 years.

#### **4.2.5 Number of times to attend the service**

Thirteen (n=13) participants have attended the service for more than one year. However, the study included two (n=2) first year students who attended the service four or more times. The researcher was of the opinion that it was a knowledgeable sample to report and describe the experiences and perceptions of the sexual health clinic under study.

### **4.3 SECTION B: THEMES THAT EMERGED FROM THE INTERVIEWS**

Seven themes emerged from the interviews conducted which are as follows:

- Awareness of the sexual health clinic
- Marketing and advertising of the service
- Operational hours
- Waiting period
- Building relationship with staff
- Consultations
- Financial Implications

Various sub-themes emerged from the seven major themes. The themes and subthemes are presented in Table 4.1. The first theme, awareness of the sexual health clinic, comprised of five sub-themes which include unawareness of the sexual health clinic, informed of services by relative/peer or other informants, staff members, services that are available free of charge and location. The second theme, namely marketing and advertising of the service include insufficient marketing and CHS staff involvement in first year student orientation. The third theme operational hours comprised of four sub-themes namely, after hours, Saturday service attendance, emergency support and fully booked. The fourth theme, waiting period included the sub-themes such as long waiting periods and contraceptive consultations. The fifth theme building relationships has sub-themes such as different staff members, comfortable communication and female staff preferences. The sub-themes contained in the sixth theme, consultations, included male doctor, nurses and attitudes of the nurse. The seventh theme namely financial implications has the following sub-themes, namely expensive doctors' consultations and referrals, inconvenient cash payments, service inaccessibility due to

overdue accounts, underprivileged/needy students, student account invoicing and incorrect account statements.

**Table 4.1 Themes and Sub-themes**

<b>THEMES</b>	<b>SUB-THEMES</b>
<b>Awareness of the sexual health clinic</b>	<ul style="list-style-type: none"> <li>• Unaware of sexual health clinic</li> <li>• Informed by relative/peer/or other</li> <li>• Staff members</li> <li>• Services available free of charge</li> <li>• Location</li> </ul>
<b>Marketing and advertising of the service</b>	<ul style="list-style-type: none"> <li>• Insufficient marketing</li> <li>• Involve CHS staff in first year student orientation</li> </ul>
<b>Operational hours</b>	<ul style="list-style-type: none"> <li>• After hours</li> <li>• Saturday service attend</li> <li>• Emergency support</li> <li>• Fully booked</li> </ul>
<b>Waiting period</b>	<ul style="list-style-type: none"> <li>• Long waiting periods</li> <li>• Contraceptive consultations</li> </ul>
<b>Building relationships</b>	<ul style="list-style-type: none"> <li>• Different staff members</li> <li>• Comfortable communication</li> <li>• Female staff preference</li> </ul>
<b>Consultations</b>	<ul style="list-style-type: none"> <li>• Male doctor</li> <li>• Nurses</li> <li>• Attitudes of the nurse</li> </ul>
<b>Financial implications</b>	<ul style="list-style-type: none"> <li>• Expensive doctors consultations and referrals</li> <li>• Inconvenient cash payments</li> <li>• Service inaccessible due to overdue accounts</li> <li>• Underprivileged/needy students</li> <li>• Invoice to student account</li> <li>• Incorrect account statements</li> </ul>

#### **4.4 AWARENESS OF THE SEXUAL HEALTH CLINIC**

This theme demonstrates that various participants were unaware that the campus health service (CHS) has a sexual health clinic.

##### **4.4.1 Awareness of the sexual health clinic: Unaware of sexual health clinic**

It became evident during the interviews that various participants, students and staff members were not knowledgeable of the sexual health clinic that is available at the CHS.

“I mean, I, I, I’ve always been aware that the, the campus health service is here ... but not the sexual health clinic, not so much, ya” (Participant 3).

“I don’t think everyone knows all the detail. Cause, like I had to ask people. And that’s how you found out that people that go there” (Participant 6).

Students are to be informed during orientation in their first year of the various services that are available at the university. Moreover, information of the services is available on the university website. It is however clear that more needs to be done to inform prospective clients of the range of services that are available.

##### **4.4.2 Awareness of the sexual health clinic: Informed by relative, peer or other**

Insufficient knowledge about the specific sexual health services offered was reported by all the clients. Clients concluded that they became aware of the specific services offered by word of mouth and upon consultation with staff members employed at the clinic.

“So I think then I realized there’s free services, ah free services um ... available to the students and then ... ya, yes and and my step sister. And then my ... ah ah usually when I got sick or something then my mom said no go to campus health” (Participant 1).

“The doctors here ... I have a, had a, a, a bladder infection. And she asked me um when what is the last time you had a pap smear, so I told her at my gyne that day. Then she said you’re not gonna do it anymore, from now on, all your sexual related problems, you come to the clinic here” (Participant 4).

Conversely, few participants mentioned that the entire community should be aware of the services as it is displayed in the university newspaper and intranet of the university and that upon orientation staff members are informed of the services. In addition, the students who live in the vicinity of the CHS, report that they became aware of the service merely because they have to pass the clinic on their way to class.

#### **4.4.3 Awareness of the sexual health clinic: Staff members**

The campus health service was established in 1974 and provided a service solely to students. In 2009 the CHS opened its doors for university staff as well. In 2009, a formal launch of the CHS was presented to introduce the services to staff. Yet, participants who were staff members were not aware that the services are available to them. In addition, the university provides a medical scheme subsidy for permanently employed staff members. Should a staff member belong to the medical scheme that is subsidized by the university, they are entitled to consult certain service providers of which CHS is one of the approved providers.

“...because the people isn’t aware that the, the permanent, employed employees at Stellenbosch University is allowed to use this facility. They think it’s only for the students” (Participant 4). And she’s working here more than 10 years [manager] for the university ... she also didn’t know that there’s a service for, for us” (Participant 4).

“Well I’ve been here for 7 years so (laughs) ... But I only started getting my, contraceptives pills here when a friend in my lab told me about it 3 years ago” (Participant 8).

The human resource department organizes a two hour information session for newly employed staff members. This information session is provided on a bi-annual basis. During these sessions the rector and vice rector delivers information to the newly employed staff members regarding SU’s mission and vision. However, services available at CHS are not communicated during these information sessions. Staff members at CHS attempt to increase awareness of the services offered at the clinic. Therefore, CHS staff members’ endeavor to coordinate at least annual visits to various departments to present information sessions about the services available for employees.

#### **4.4.4 Awareness of the sexual health clinic: Certain services are free of charge**

Certain contraceptives and medication are subsidized by the Department of Health in South Africa. These medications are available free of charge at the sexual health clinic. Various participants were not aware that certain services e.g. particular contraceptives, HIV testing and antibiotics are available free of charge at the clinic.

“Like he always came here for a doctor and he didn’t even know that you get the nurse option. Like certain things I do feel like ... You don’t really know until you come here or you find out, cause ... and he’s also on his 3<sup>rd</sup> year and he never knew that up until last that you can actually come here to see a nurse” ... “So I feel like people do need to know what they offer and they do need to make it a bit like, they just have to let you know that you can come for



this. Let you know what, I feel like is, like an AIDS test is free. Um like cert ... if you certain antibiotics like for STDs and stuff they are free. I feel like people knew that, they would come here" (Participant 11).

"Cause also you don't know what contraceptives are free, what are the ones that you pay for, how much are they. I actually had to come this year to find out myself how much it was. Cause you, you knew there was ones that you pay for but you don't know much. So a lot of the information you don't know" (Participant 6).

Besides the subsidized medication, consultations with a RPN at CHS are free of charge. Therefore clients receive free services should they use subsidized medication and utilize the services of the RPNs at the sexual health clinic. Yet, should the client decline the subsidized medication, clients have to pay for the medication of their choice. The quotations demonstrate that more should be done to inform prospective clients of services that are available at the CHS and moreover about the services that are provided free of charge.

#### **4.4.5 Awareness of the sexual health clinic: Location**

Stellenbosch resembles a university town with residences and lecture halls that are situated over a wide geographical area. The size of the SU main campus grounds are 4 481 667 m<sup>2</sup> (Willoughby, 2014:np), which includes all areas owned by the university. The CHS is located in the vicinity of the student residences that are located off the central campus towards the eastern vicinity of Stellenbosch. Yet, a variety of student residences are situated on the north, south and west side of the town. The CHS is situated in Claassen Street between two student residences. Neither of the entrances to Claassen Street has direction boards stating that the CHS is situated in this road. In addition, there are no direction boards from central campus to the clinic to guide the campus community to the clinic.

"Um, I'm currently staying in Goldfields residents, um it's like 20 minutes' walk, it's quite far but ya it's, it's difficult to get here because I have to walk a long distance. Um and also ... I don't know, but I don't think they can move to any place closer to campus like around campus, because you know, it's a small place here" (Participant 2). However, Participant 2 relates that the location was not hard to find because she was showed physically by mentors during orientation week.

"Because like for students to get involved, like you would actually like this is on campus but it's off central campus like you have to make it visible on that side, not on this side, cause only people who live here come on this side" (Participant 11).

The CHS are not centrally located and directions to CHS from the main lecture halls, the administrative buildings of the university, and the residences on the opposite side of the main lecture halls, are currently absent. Subsequently a student, who lives off campus or not in the residences close to the clinic, might not know where the clinic is located. Therefore, students who are not residing in the residences close to the CHS should be better informed about the location of the clinic.

All the other sub-themes, that is clients who are not knowledgeable about the availability of the services, the variety of services and what services are indeed free of charge, demonstrates a need to increase awareness and knowledge of the university community about the CHS .

#### **4.5 MARKETING AND ADVERTISING OF THE SERVICE**

This theme consist the participants requests for marketing and advertising of the services available at the clinic.

##### **4.5.1 Marketing and advertising of the service: Insufficient marketing**

The participants revealed that a lack of knowledge existed regarding the availability of services at the CHS. The lack of knowledge is seemingly related to the insufficient marketing and advertising strategies of the services.

“I think they should do more campaigns around university, they already do the campaigns but, you know it’s not enough, like maybe once a year they do like a, a testing. But then they, they should actually do like a presentations around faculties or they should do campaigns and ya, so that people can know about it” (Participant 2).

“I haven’t seen posters of the place” (Participant 9).

Participants claim that when they initially enrolled at the university, they were not informed about the services during the orientation period. However, other participants claim that they had been orientated and informed during the orientation period and even physically brought to CHS by their mentors. It therefore seems that not all mentors involved in the orientation of students are thorough, or perhaps knowledgeable, about the availability of the service.

#### **4.5.2 Marketing and advertising of the service: Involvement of CHS staff during first year student orientation**

First year students are informed about the CHS by the senior student orientation team. During the orientation week senior students have a treasure hunt day, of which one of the treasures to find is the CHS.

A 'Student Success Expo day' is held for first year students in January each year. The CHS staff members are afforded the opportunity to provide information regarding the services rendered at the clinic to the students. Newly enrolled students are provided with a CHS registration form. Should students complete and submit the form to the CHS representative; their details are loaded on the computerized system of CHS. Students, who do not have all the details with them to complete the form during the 'Student Success Expo day', are advised to complete the form and personally deliver it to CHS.

"I don't remember actually seeing anything when I arrived in 1<sup>st</sup> year so with regards to that they could actually do more. Because when 1<sup>st</sup> years come there's like an initiation day like different societies and stuff that sit in the Neelsie (the social center at the main campus in Stellenbosch) if they could actually put up a table there in the Neelsie, I don't think I've actually seen their table, but like ya. It would be great just to inform students that there's such a service that's available on campus" (Participant 5).

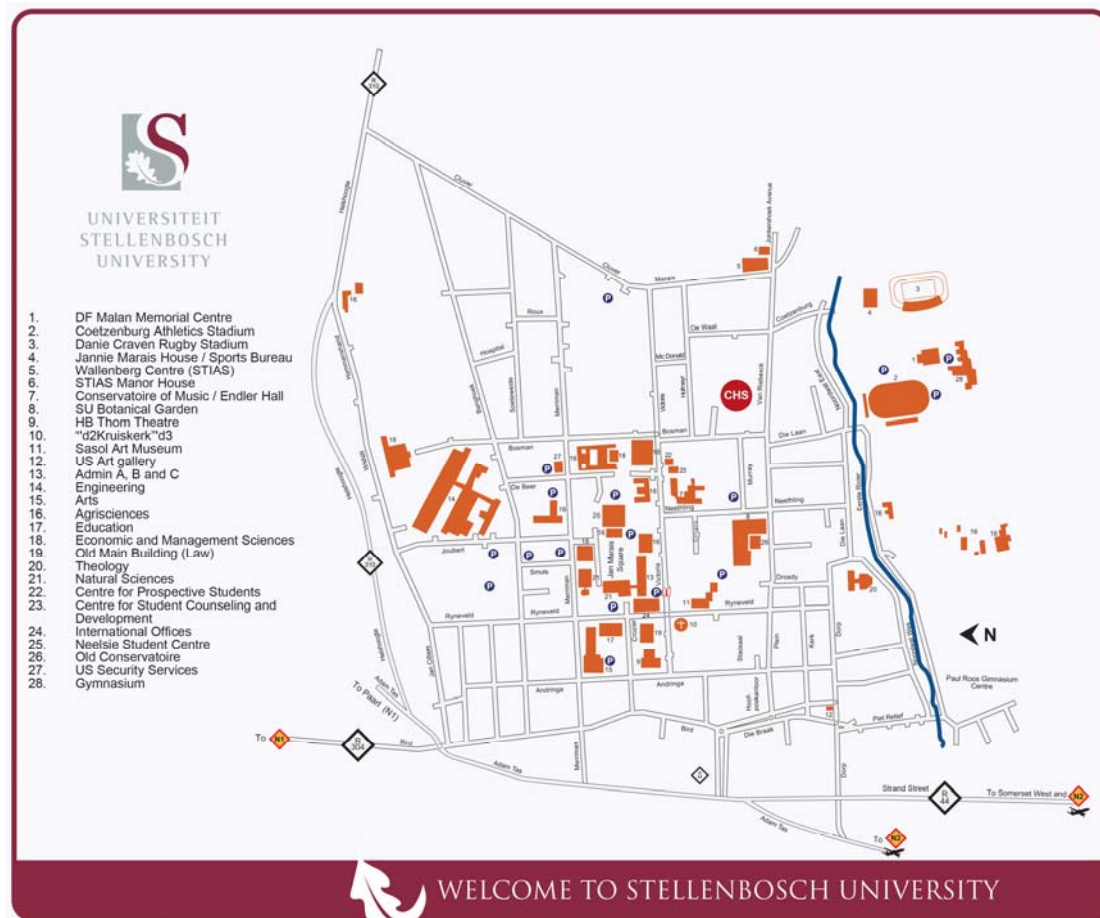
"So, but she didn't have any clue of where it is and she sort of didn't hear about it before either. So maybe they could include that in the welcoming program for the first years. That could potentially, like I don't know, sort of introduce them into the whole idea that there is doctors on campus" (Participant 8).

It appears that marketing and advertising play a major role amongst participants as a means of being informed about campus issues. Likewise an introduction about the CHS might be more efficient when staff members from CHS represent the clinic during orientation. According to participants marketing and advertising would greatly benefit clients who live off campus and would be particularly informative specifically for the first year students.

#### **4.6 OPERATIONAL HOURS**

Various students who participated in the study commented that the operational hours of the clinic are inconvenient since students have to attend classes between 08h00 and 17h00. Should they visit the clinic between 08h00 and 17h00 some could miss a scheduled class. The students also commented that it is often difficult to attend the service during their lunch break. The possibility of visiting the clinic during lunch break depends on the location of their

classes. The lecture halls are situated over a wide geographical area and some are not within walking distance of the clinic. The location of CHS is illustrated in the following map (see Figure 4.1).



**Figure 4.1** A map of the main campus, Stellenbosch University (Stellenbosch University main campus map, nd:np).

#### 4.6.1 Operational hours: After hours

The operational hours of the sexual health clinic are 08h00-17h00, Monday to Friday. Participants who are staff members were satisfied with the operational hours of the clinic since they could visit the clinic during working hours or their lunch break. However, several of the participants who were students expressed dissatisfaction with current operational hours.

“And maybe if it had longer, operating hours ... that, not just for me, but for other students that might be studying throughout the day ... that they can either go before classes if they open at 7 or maybe after 7 if they close at 7 or 8 o’ clock. I think that might be quite beneficial to the student community” (Participant 15).

Except for a private pharmacy, which is available during the day at the social center of the university, the CHS is the only healthcare facility available on campus for students. Since a large number of students are residing in the students' residents on the main campus, students rely on the CHS for health care services. Therefore, various students requested that the services of the facility be available after hours.

#### **4.6.2 Operational hours: Saturday service attend**

The majority of students have classes scheduled from Monday to Friday. Some are therefore unable to visit the clinic during normal operational hours. Various participants requested that the services of the clinic be available on a Saturday morning.

“Ya, maybe just short hours, maybe like on a Saturday morning from 10 to 1, or something like that cause then you can still, ok it opens at 10, yeah, (laughs), guess I will stay alive...”  
(Participant 1).

“...Maybe if they just open on a Saturday, let's say from 8 till lunch. That would help”  
(Participant 5).

The students were of the opinion that the availability of clinic services on a Saturday would be more convenient during specific time periods such as examinations and in winter, when students tend to fall ill. Many students occupy the campus residence on weekends, especially those who have to study for examinations and those who do not have family members nearby to visit. Therefore, it would be beneficial to have the services available on a Saturday.

However, several students reported that their class schedule is flexible enough to visit the CHS. Conversely, a student with a busy schedule finds it difficult to make time to attend the service during class. For those students it is an inconvenient rush during class periods and they are often late for their next class. It was also reported by a participant that the CHS offers medical certificates if classes were missed, but the fact remains that they do not want to miss the class at all.

#### **4.6.3 Operational hours: Emergency support**

Participants reported that emergencies usually happen at night when no onsite health services are available. Consequently, without having transport to private services or medical aid, they would rather wait till the next day for a consultation at the CHS.

“And also I think most serious emergencies actually happens at night. So it is a bit. It doesn’t accommodate the student perfectly because of that times. But I can also understand that they, they can’t be here whole night and 24/7” (Participant 6).

“And because they knew me, like because I was always here and because I had my operation. And I told them about it and I told them what was happening like they helped me immediately. So I do feel that in an emergency they can help you though” (Participant 11).

Some student participants mentioned that they could walk to a public or private healthcare facility in case of an emergency. Yet, if they were ill, this would not be possible. The university has a twenty-four hour protection service department on campus available to students that provides assistance and transportation to medical facilities during emergencies. In addition, students have access to the Stellenbosch public hospital which is situated seven hundred and fifty meters from the main campus. Stellenbosch Medi-Clinic (a private hospital) is situated three kilometers off campus (Google Maps, 2014).

#### **4.6.4 Operational hours: Fully booked**

Four medical doctors are employed at the CHS. One of them has a specialist qualification in occupational health. A fifth doctor is employed on a locum basis. Clients who wish to see a doctor are required to schedule an appointment with a doctor. Four RPNs are employed at CHS. Two of these nurses have a specialist qualification in occupational health. Three of them have a diploma in primary health care. In the event that clients need to see one of the nurses an appointment is not needed. Some student participants, revealed that the clinic is usually fully booked with appointments (to see a doctor) from the day before or early in the morning and this causes frustration amongst clients.

“Ok, um, with the appointments, you have to make an appointment with the doctor, and with the nurse you can um you can get the nurse the same time that you arrive, anytime. But with the doctor it’s quite a problem...” (Participant 2).

“Um but the last 2 or th ... I think 3 times I’ve been here um, I’ve had to have made an appointment only because they’ve been quite fully booked” (Participant 15).

The total population of the campus community, including students and staff members, is 31 241. Over the last two years, 2012 and 2013, respectively 2 517 and 3 360 clients visited the sexual health clinic (Stellenbosch University Statistical profile, Core Statistics, 2013; Campus Health Service Statistics, 2012, 2013:np). The staff member who deals with the scheduling of appointments considers a minimum consultation time of at least 15 minutes. Of the four

doctors who are employed, three doctors are available for clients every day, Monday to Friday. The doctor who has an occupational health qualification deals mostly with occupational health cases.

In the event of a fully booked doctors' schedule, the nurse offers a consultation to the client. Usually when clients insist on seeing a doctor, the nurse would see to their immediate needs and arrange an appointment with the doctor for the following day.

#### **4.7 WAITING PERIOD**

Another key aspect that emerged from the findings was the waiting period for consultations.

##### **4.7.1 Waiting period: Long waiting periods**

Clients who wish to consult a doctor are required to make an appointment via the administrative staff at the clinic. The participants were of the opinion that often, irrespective of the appointment with a doctor, they wait quite a long time in the waiting area, since the doctor with whom they have the appointment, is in consultation with a client.

"Um, sometimes, depending on ... what day it is, sometimes it's busy and sometimes it's not. Um, I have been here when like, the, I had to wait a while because they're busy. Um there was a time when I had a lot of problems and, I think I was a bit rude because I had to wait and I didn't have time and I had appointments to go to and then ah, I had to wait a while a little while and ya I threw a little fit, once or twice (laughs)" (Participant 9).

"Cause sometimes you have an appointment at 11 but you actually go in at 11:30" (Participant 5).

An appointment is, however, not required should the client wish to see a nurse. Clients consult with the nurse on a walk-in basis and on a first-come-first-served system. However, depending on how busy the clinic is, a client may have to wait before the consultation with the nurse takes place.

"So yes. If you had to choose a bad day when everybody's got a cold and you want to see the sister then it's quite a long wait. Which, think could be slighter nicer if you could phone and make an appointment to see the sister as well" (Participant 8).

The administration officials responsible for the scheduling of appointments work with a norm of fifteen minutes per consultation. Each doctor accommodates scheduled consultations for thirty-one clients per day. It often happens that a client with a complex condition requires

more than fifteen minutes. Hence, the next client is not seen promptly and that results in students not being on time for their next class.

In addition, clients have a waiting period for the nurse. According to the CHS computerized diary system, nurses are able to consult twenty-nine clients per day. However, in addition to these twenty-nine consultations, the nurses serve clients who are referred to them by doctors at the campus health clinic. These clients often require lengthy procedures, which increases the waiting period for clients waiting to see the nurse.

The information provided above describes the factors that influence the waiting time of the client.

#### **4.7.2 Waiting period: Consultation for the issuing of contraceptives**

Some clients have the perception that oral contraceptives may be purchased from any staff member, not necessarily a doctor, pharmacist or RPN and without a consultation. However, oral contraceptives are scheduled medication meaning that they can only be issued by a health care provider who is in possession of a dispensing license. Contraceptives are a hormonal treatment. For this reason clients have to be observed for side effects. For example, upon introducing contraceptives, the health care practitioner has to obtain the medical history of the client and evaluate whether contraindications for contraceptives exist. Upon initial commencement of the contraception, blood pressure and weight are checked. These measurements serve as baseline data since hormonal treatment may affect both the blood pressure and weight of the client. Therefore, it is necessary that the client has a consultation with a health care provider. The consultation should however include appropriate health education.

Several students are seemingly not knowledgeable about the reasons underlying the consultation that precedes the dispensing of contraceptives. Various participants commented that the consultation with the nurse that precedes the issuing of contraceptives is irrelevant or unnecessary. This viewpoint was evident specifically amongst clients who have been on contraceptives for several years. The findings also revealed that quite often students have to wait more than half an hour for a nurse to assist them.

“I think a lot of the majority of the girls coming in here just quickly wants to buy their monthly pill or whatever. I actually, I've waited here for 45 minutes and I have class, I have a test and I can't sit here I need to practice and er and then that's a little bit frustrating because it's not a serious thing obviously if it is serious you need to see a doctor and you'll be, ya willingly need



to wait. But I think you need a sister in a small room or at a pharmacy or something like that where you can just quickly go in and buy your pill and go out, almost something like that or something that just like a in and out thing. Now you just sitting there for 45 minutes just to buy a small packet hahaha. that's very frustrating because it's not and I think you also take the time from the sisters that needs to help somebody with a serious issue or with a more serious issue than just like a consultant or what do you call it? Um a cashier almost, you know..." (Participant 1).

Three RPNs are available Monday to Friday and an additional RPN (who deals with occupational health services) is available on Tuesday and Thursday afternoons for sexual health consultations. The duration of the consultation time depends on the needs of the clients. The minimum consultation time is fifteen minutes.

The findings (the lack of knowledge of the reasons underlying the consultation) signify a need to enhance health education among clients attending the clinic for contraceptive purposes. Moreover, the lengthy waiting period mentioned by clients suggest a need to employ more RPNs at the clinic.

#### **4.8 BUILDING RELATIONSHIPS**

The sexual health clinic is manned by three RPNs. However, the occupational health nurse is available to assist twice per week. The participants reflected that with each consultation they are attended to by a different nurse, not necessarily the same nurse that provided the service on the previous consultation. They were not very comfortable with this arrangement.

##### **4.8.1 Building relationships: Different staff members**

Participants reflected that continuous care and comfortable relationships could be improved if they could see the same staff member at each consultation. It could provide a feeling of security and safety and make it easier to talk about sexual health issues.

"Um they always very friendly and very nice if there's one thing I would say is lacking because I've now actually, just recently um found a gyne here in Stellenbosch that I'm now going to. Um and I think the reason for that is just because that person is gonna get to know me a little bit better. Whereas here it's, you know, it's with a different person, and um so it doesn't feel like you kind of sort of buildup that relationship with that person. You need to see a different sister every time, um it's not predictable in that way. So they always very nice and very friendly and very pro, professional but I feel that, when I go to my private gyne that it feels a little bit more...personal maybe, that she takes, you know, sees me as a patient she's gonna see a lot and knows me, you know and spends quite a lot of time, you know asking me questions that I would maybe get from, from the sisters here" (Participant 3).

“I think the only thing that is a bit of an issue is that whenever you come you see someone different. So now it's not the same person, so you kind of have to explain sometimes to the different people the same story” (Participant 6).

Clients experienced the consultation to be more comfortable if they are attended to by someone who is knowledgeable of their medical history and preferably the same person that they had seen at their previous visit to the clinic. Subsequently, they do not have to explain personal issues to a different nurse. Participants also mentioned that if they could see a specific person at every visit, it would be likely that they would attend the service more often. Building relationships and trust with staff members seemed to be an important part of consultation. This was the view of various staff members and students.

#### **4.8.2 Building relationships: Comfortable communication**

Considering the age of participants who are students (20-25) and the fact that they are separated from their parents and family, they require an environment with people they can trust and feel comfortable to communicate with. Participants reflected that it is indeed what they experience with staff members employed at the clinic.

“...it's sort of incorporated into the university system, so like when you come they ask for your student number, and stuff like that, so you still feel, I don't know, sort of protected like you still in your safe shell rather than going somewhere else outside where you don't know what to expect. But here you know, you're with your people, so, ya” (Participant 5).

“The thing is I have a ... another doctor, like my home, my doctor at home, cause I live on the res. But I do feel the fact that, like they work with students, I feel that they a bit more understanding. Because they deal with students everyday so its bit easier in that sense. Because like, if you go to an outside doctor ... like with certain issues you just feel uncomfortable but I do realize like they work with certain things all the time, so I just feel a bit, more comfortable I guess” (Participant 11).

The conclusion is made that staff members at the clinic, doctors, nurses and receptionists, offer a welcoming atmosphere to the campus community. According to the findings it is evident that both student and staff members felt that the CHS is like a comfort zone to them, and even an “extension of their home” (Participant 15). “I can honestly say I do feel at home when I'm here” (Participant 14).

#### **4.8.3 Building relationships: Female staff preference**

Currently CHS have four female RPNs and five doctors of which two doctors are male. The clients who attend the sexual health service are mostly females. The clinic provides for their contraceptive needs, routine cervical smears and a variety of other sexual health needs. Some female participants showed a preference for female doctors as they relate that they are more comfortable discussing sexual health issues with another female.

“Especially it, when it concerns my sexual health, or when I feel shy to talk to them...And what’s nice is I when phone and I can ask for a female doctor. I usually ask for a female doctor to see me” (Participant 9).

“You know there are a couple of, the, the there’s two male doctors, if I’m right. I think there’s two. (Laughs). And um they’re also very nice but I personally I prefer the females cause I, I, I think it’s just a women thing” (Participant 14).

Another participant concluded that with clients having preferences, maybe upon arranging an appointment, the receptionist could possibly enquire if there is a preference for a specific staff member.

“I just normally say can I see the sister and ... you know, I don’t know if they maybe just ask if there’s someone specific you’d like to see” (Participant 3).

Participants reveal that if they could consult with the staff member of their preference each time, it would create a more comfortable atmosphere to speak about sexual health issues. In addition they report that it would enhance treatment and outcome.

### **4.9 CONSULTATIONS**

This theme comprises the participants’ perceptions regarding medical conditions for which they have attended the service.

#### **4.9.1 Consultations: Male doctor**

CHS does not have the necessary equipment available for certain procedures, for example x-rays and ultrasounds. The doctors employed at CHS, except for the occupational health doctor, are general practitioners. Clients who require procedures such as ultrasounds or services provided by specialists are therefore referred to a private practice that provides these services. The CHS staff member who refers the client liaises with the specialist regarding results and the client is requested to arrange a follow up appointment at CHS. The first follow up consultation after the procedure is exempted from consultation costs. However,

the client must pay for any medication dispensed. Yet, in the event where the client has a consultation for the same condition, for example a week later, a consultation fee will be invoiced.

A participant was of the opinion that consultations with male staff members interrupted treatment options and diagnosis. In addition it influenced financial aspects. The quotation below shows that not all doctors would complete an internal examination on a female patient. According to the participant the doctor who treated her at CHS, did not perform an internal examination but instead he referred her to a gynecologist. Yet, the final outcome is that she did not have a gynecological problem but a bladder problem that indicated a need for an urologist. According to the participant she expected an internal examination that was not done and was simply referred to a specialist which she found costly.

“But ya because I have, I still have a problem (giggles) that’s happened and it still hasn’t been solved, solved yet, so I don’t know, because I don’t know if I need to come back here because I don’t know about if he will be actually be able to help me, because all he did was, and ok and I understand that he was he’s a man and he, he felt that it was un ... inappropriate to just um what you call it ondersoek (examination) there (giggles) ... because it’s something with my bladder but then he sent me because he thought It’s like a another problem um like with my what you call it? With my baarmoeder (uterus), what do you call it? ... so he sent me to the gynecologist but she said no that’s fine, everything’s fine, so I think it was because of my bladder so now I don’t know if I have to go to a specialist ... they just checked for um infections but now there weren’t any, so there weren’t any, like ok so it’s not an infection so maybe it’s this, or ... Obviously he did but he still ya with the gynecologist but now that’s cleared, but, now, now what do I do now? I have to pay another twenty, two hundred and fifty rand or whatever the consultation is, just to find out he doesn’t know. Something you know. So I’m just going straight to the maybe just to the, the bladder doctor (giggles) because ... ya” (Participant 1).

It is evident that clients should be thoroughly informed as to why they are referred to specialists in order to understand the necessity of the referral.

#### **4.9.2 Consultations: Nurses**

The majority of participants who are students verbalized that they require more detailed information on the treatment that they receive from nurses at the clinic. According to them the information that they obtain from some nurses lacked important depth.

“I always try to get their, their opinions but it’s very limited, most of the time. Sometimes they will just tell me, that one is stronger than the other one that would be it. Where I would have

liked to know more from my knowledge I do know that it is difficult to say if one specific person will, but I also, I do expect them to actually know that majority of people maybe complain about picking up weight something like that. I, I'm not sure sometimes, maybe they, they don't know or maybe they don't think it's important" (Participant 6).

The nurses at CHS are supposed to offer counseling and education upon each consultation. In addition to a primary health care qualification, all the RPNs have a competency certificate to provide a sexual health service. All staff members at CHS receive in service training which takes place on a weekly basis on various health related topics.

In contrast other participants were of the opinion that the nurses fulfill their needs and that they are supportive and knowledgeable.

"Staff would refer clients if they are unsure of treatment options. They're very clear on what they're telling you, about this is what you need, this is the treatment and they can all, they can advise you. Um this would be best for you, are you ok with this or not, this is the second options" (Participant 7).

"And then, she told me but this would help for it ya she explained to me. I can't remember who it was, what sister it was, but um ya she explained it quite clearly to me, how it works, so" (Participant 10).

The nurses at the clinic are dealing with students who are studying at an institution of higher education. Therefore, the nurses should consider the education level of the client and ensure that the information that they provide contains a balance between colloquial and scientific language as well as depth.

#### **4.9.3 Consultations: Attitudes of the nurse**

Regardless of the positive feedback regarding staff members in 4.8.2, comments were received that demonstrate that some nurses might not be very friendly and are perhaps judgmental towards clients that request contraceptives.

"Most nurses are very nice ... most of them are very nice, very approachable. Some nurses are, nors (grumpy) if you can say it. So they not very approachable, they don't look very friendly, but most are" (Participant 6).

"Especially as a girl coming for contraception then you feel like they judging you or they ask, they thinking why you here, such stuff" (Participant 6).

The comments indicate that clients are indeed conscious about the attitude of staff and whether nurses consider or judge clients who attend the clinic for contraceptives.

#### **4.10 FINANCIAL IMPLICATIONS**

This theme comprises the participants' viewpoints regarding financial issues.

##### **4.10.1 Financial implications: Expensive doctors' consultations and referrals**

The participants, who were staff members at the university, were of the opinion that the services are inexpensive. It appeared that students, who belong to a medical aid scheme, do not regard the services at the clinic as costly. However, students who pay for their own studies, do not have medical aid benefits and work part time to earn extra money, had difficulties with the fee system at CHS.

"...they also very helpful with that [referrals], but then it's also a thing about yes now I have to pay a ... er a lot of money ... now what do I do now? I have to pay another twenty, two hundred and fifty rand or whatever the consultation is" (Participant 1).

"The only issue I have is, sorry. The doctors, because it's also cash it's a bit expensive, cause it's R250" (Participant 6).

The findings above indicate that students with no medical aid benefits consider doctors' consultations expensive. The expense increases should they be referred to another doctor or specialist, since it means that they need to pay the doctor at the CHS in addition to the doctor to whom they have been referred.

##### **4.10.2 Financial implications: Inconvenient cash payments**

Currently at CHS, a fee of less than fifty South African Rand (R50) has to be paid in cash. For example, the fee for a urine or pregnancy test is R15. Up until August 2013, CHS did not have an electronic cash card payment machine in place. The cash card payment system was not formally introduced at the time of data collection. Prior to the introduction of the cash card system, students who do not belong to a medical aid scheme had to visit a bank to draw money before coming to the clinic. Others who forgot to pay their account at the CHS are reminded about the account via email.

"But er, yes I think card machine, (giggles) I think a lot of people will actually pay their bill more promptly as well because it's a thing like ok I've just been to the doctor, ok let's pay but now like oh I don't have cash on me. Ok, ok, and then they get, they busy and then they forget

about it even if they get the e mail it's just like oh no I can't now, I don't, I can't draw money and walk all the way here" (Participant 1).

"...with the pay system um because they give you like a notice to pay that amount of money that you owe, and you have to pay cash sometimes it's a problem, especially when you went to see a doctor, because the doctors are expensive" (Participant 2).

For some students the payment system is even more inconvenient. Students who do not have money in the bank need to acquire cash to pay for certain services at the clinic.

"Because especially with this like now, you have to, if you wanna get a pregnancy test done here, you have to pay cash now. Before that was not in place. So that I do feel is inconvenient, because it's like ... if you don't have the money then what do you do though, are you just not gonna know or where do you go" (Participant 11).

Students who had cash available found it difficult to make payments as there were no electronic card machines up until August 2013. Yet, students with no stable income or money found cash payments even more problematic since no cash meant that they could not attend the services. The findings therefore reveal a need to accommodate students with financial problems.

#### **4.10.3 Financial implications: Service inaccessible with overdue accounts**

Participants relate that it often becomes difficult to consult with a doctor when finance is unavailable and when accounts are in arrears. Participants are resentful that the service becomes inaccessible to them and attendances to health services are denied.

"Ya sometimes when my account is behind then I can't see a doctor which is understandable. I can't even see a nurse which is sometimes frustrating, um but I guess that's just part of life when your payments are behind and you can't see a doctor" (Participant 9).

Accounts are sent via e-mail to each client who attended the services at the clinic, indicating the balance that the client has to settle. In incidences where the medical aid scheme of a client rejects financial claims issued by CHS, the client would be liable to pay the outstanding amount. Clients have a period of thirty days to settle an account. Once the account is overdue for ninety days or more, the financial department has a short discussion with the client. Payment arrangements are made during these discussions. Depending on the clients' payment history, the financial department would either allow them to consult the doctor or are given the option to consult with the nurse which is free of charge. However, the client is liable

to pay cash for any medication dispensed. This rule applies for clients with or without medical aid schemes.

#### **4.10.4 Financial implications: Needy students**

Students who participated in the study were of the opinion that financial issues had an influence on access to the service.

“Don’t have money and then like what you supposed to do? Because, like not everybody is as privileged. So I do feel like people, like a lot of girls on campus like they have, I feel like they need to be able to go to a place and like, get themselves sorted out. Cause as a student the ... like a lot of people just don’t have money that is like their main reason for not coming to a doctor, like they just don’t have money” (Participant 11).

Participants were of the opinion that some of them experience financial constraints and are therefore not able to utilize the full spectrum of services that are available such as a consultation with a doctor. The latter becomes inaccessible to them.

#### **4.10.5 Financial implications: Invoice to student account**

Since the CHS is a service provided by the university, participants were of the opinion that the accounts for services delivered by the CHS to students should be billed against their student account, meaning their class fees.

“Um I think, for me they should charge it in the student account and then maybe at the end of the year then you can be able to pay that amount of money, instead of just paying cash, because they’re part of the university ... ya” (Participant 2).

Direct cash payments to the CHS for medical care seemed to be costly for the student budget.

#### **4.10.6 Financial implications: Incorrect statements**

The accounts of clients attending the CHS are managed by two administration officials stationed at CHS. Neither of the two officials have a formal qualification in accounting. Participants revealed that they receive incorrect statements for accounts they have already settled. The mistakes are usually fixed after much effort and communication, ultimately causing frustration for the participants.

“Um, the only thing which has got, probably nothing related to the, just to the health care sector, is the financial people (laughs). They sort of messed up a record because you pay for



your pills when you receive them, you don't, you can't pay for them at later stage like, in 30 days' time. So I came to see the doctor, when I wasn't feeling well. And then they sent me the bill a week later, which is, what they're supposed to do. But then the lady at finances or whoever put the pills amount on the receipt as well, which was already paid. And, ya it was a bit of a mission getting her to cooperate via email and she sent me the same thing 3 times and I ended up, I just came here and I told her look, the invoice is not correct can you please tell me what's going on, ya and give me a new one so that I can pay you now. And then she said, oh no it was a mistake and I, I already fixed it on the system but she never let me know, and that was 2 months later" (Participant 8).

The administration officials responsible for financial issues at CHS attend annual workshops. One official was engaged in an advanced course appropriate to financial aspects. The officials function under the guidance of, and in collaboration with, the university's financial department. The responses of the participants however, indicate that more should be done to ensure quality service delivery in this regard.

#### **4.11 SUMMARY**

In this chapter the findings of the study were presented and discussed. The findings confirmed that student and staff participants had different views regarding their experiences with the sexual health clinic under study. Opinions regarding awareness and marketing of services, operational hours, waiting period, the building of relationships with staff, consultations and financial implications, were all factors that influenced participants' experiences and perceptions of the service rendered at the clinic.

Chapter 5 consists of a discussion of the findings of the study and recommendations are made based on the scientific evidence obtained in the study.

## **CHAPTER 5: DISCUSSION AND RECOMMENDATIONS**

### **5.1 INTRODUCTION**

Chapter 5 contains a discussion of the findings of the study. The achievement of the study objectives is demonstrated and conclusions are drawn based on the findings as they relate to the objectives of the study. A description is provided on the limitations of the study and recommendations are proposed to improve service delivery at the CHS.

### **5.2 DISCUSSION AND RECOMMENDATIONS**

The aim of the study was to explore the experiences and perceptions of clients attending a South African university sexual health clinic. A discussion of the findings of the study in relation to each objective is presented.

The two objectives of the study may interlink and therefore the discussion of clients' viewpoints may be convergent.

#### **5.2.1 Objective 1: To explore the experiences and perceptions of the clients attending the sexual health service at SU CHS regarding service delivery.**

##### **Awareness and location**

Various staff members and students were not aware of the existence of the CHS, the variety of services that are available, specifically the sexual health clinic and the availability of services that are free of charge. Awareness is seemingly created by word of mouth. Many had problems locating the clinic since the clinic building is not centrally located. Furthermore, there are no direction boards from the main campus to the clinic.

It is therefore clear that efforts are required to increase awareness, the visibility and the location of the CHS. Geographical location is an important aspect of health care service accessibility. The attendance of clients at the health services decreases as the location distance of the facility increases (Hiscock, Pearce, Blakely & Witten, 2008:2185). The distribution of facilities, not only limits access, but also has serious consequences for medical conditions and emergencies (Muhammed, Umeh, Nasir & Suleiman, 2013:660). Television, newspapers, internet, bill boards, radio, family and friends are the main modes for students to obtain health related information (Singh & Begum, 2010:8). Therefore, modes of communication such as the campus magazine, the university intranet and billboards in the vicinity of the university, could assist in creating awareness of the service. However, impersonal communication through printed materials and other media forms could

discourage clients from exploring clinics and the variety of services that are available. Therefore, it is preferable to communicate with clients by making direct personal contact such as via awareness campaigns and information groups (Scheppers, Van Dongen, Dekker, Geertzen & Dekker, 2006:344). Subsequently, efforts to enhance awareness should be concerted and well planned in order to be effective (Singh & Begum, 2010:8).

### **Accessibility and operational hours**

Except for the lack of awareness about CHS, the findings demonstrate that the operational hours of the clinic are not convenient for students since they overlap with the class schedules. Since CHS is not centrally located, students without transport have to walk long distances to the clinic and might therefore miss a scheduled class. In addition, after hours emergency support can only be obtained at the public or private hospital.

The location and distribution of health care services, as well as transportation to health care services, has received increased attention. The distance of health care services affects access and attendance of the facility. However, distance alone as a barrier does not fully explain accessibility to facilities (Paez, Mercado, Farber, Morency & Roorda, 2010:2). Operational hours can act as a barrier. Therefore, the use of flexible clinic hours has been fairly successful in adapting care to the need and expectations of clients. Consequently limited and inconvenient clinic hours are disadvantageous with regard to access to service (Scheppers *et al.*, 2006:344).

### **Availability of health care personnel and waiting periods**

Accessibility of services was also problematic as the doctors were often fully booked (see Chapter 4, Section 4.6.4). Some clients who were able to arrange an appointment with a doctor were not able to consult with the doctor promptly as arranged. They frequently are required to wait irrespective of the scheduled appointment since the doctor was in consultation. Quite often, they have to wait more than half an hour before being able to consult a nurse (see Chapter 4, Section 4.7.1). These waiting periods for doctors and nurses cause frustration as it means that the student might miss a class.

The cumbersome process of making and obtaining appointments and the prolonged waiting times are factors that influence access to service (Scheppers *et al.*, 2006: 344). Waiting periods at clinics have been observed to be long and resulted in a sense of dissatisfaction with the provision of services. The long waiting periods increases the clients' anxiety and is frequently cited as a reason why clients leave a practice. Feelings of dissatisfaction and anxiety could be prevented by providing comfortable waiting areas and through ensuring that

clients are not in discomfort or pain. Service providers should also explain the reason for the waiting period and perhaps offer current magazines and a television to occupy clients during the waiting period (Press Ganey Associates, 2009:1-2).

### **Consultations: contraceptives**

In addition, some clients reflected that they have experienced long waiting periods for a consultation with a nurse to purchase contraceptives. Some regard the consultation with a nurse for the purchase of contraceptives, as unnecessary (See chapter 4, section 4.7.2). This indicates the possibility that clients are not knowledgeable with regard to the underlying reasons for the formal consultation (the underlying reasons for the consultation were explained in Chapter 4, Section 4.7.2). Moreover, the possibility exists that health education could be neglected. Consultation sessions are an opportunity for health care professionals to provide information to clients regarding sexual health such as the risk of pregnancy, sexually transmitted diseases and the use of contraceptives correctly and consistently (Spear & Clark, 2008:46). Lopez, Hiller and Grimes (2010:9) aver that there is an increase in the use of contraceptives and a reduction in unplanned pregnancies when clients receive effective education during consultations. Moreover, it is also important for health care providers to understand how and the reason why clients make certain contraceptive choices. It is evident that insufficient health education during consultations results in the clients' noncompliance because of the lack of knowledge regarding contraceptive use. Therefore, monitoring compliance through follow-up visits is of benefit to improve compliance (Walsh, nd:95; Culwell & Hillard, 2008: np).

### **Consultations: relationship building**

Sexual health consultations are seemingly more comfortable when consulting the same health care provider upon each consultation (see Chapter 4, Section 4.8.1) and building a relationship with the health care provider; the latter seemingly enhances treatment and outcome (see Chapter 4, Section 4.8.2). Literature confirms that clients are uncomfortable having to consult with a different healthcare provider each time they access the service (Booyens, 2008:270). Moreover, the relationship between provider and client is a remarkable aspect in the medical process and the clients' expectations in health care tend to be high, which necessitates trust in service delivery (Anshari & Almunawar, 2011:79).

### **Consultations: gender issues**

Notwithstanding relationship building, female student participants were more comfortable discussing sexual health issues with a female staff member (see Chapter 4, Section 4.8.3). Female clients are often embarrassed with a physical examination, especially internal

examinations performed by male clinicians (Scheppers *et al.*, 2006:344). Females feel more comfortable discussing sexual health and intimate relationships with female providers. There may be additional barriers between female clients and male providers when discussing sexual health issues (Politi *et al.*, 2009:515). Client satisfaction with health care is an important indicator of quality and the outcome thereof. The client as the receiver of the service is the only one who can judge the quality of the service rendered. Therefore the providers should focus on the clients' values and preferences (Booyens, 2008:269).

Other findings suggest that a male doctor could be uncomfortable with performing an internal examination on a female patient and would rather refer the client to a gynecologist (see Chapter 4, Section 4.9.1). The referral implies additional medical expenses which could have been prevented should doctors perform the internal examination themselves. Literature confirms a tendency among primary care physicians to refer clients more quickly than needed to a specialist (Scheppers *et al.*, 2006:342). Females experience many discomforting and embarrassing feelings during internal examinations. Hence, doctors use this view as a justification for not doing internal examinations. In addition, even doctors have anxieties regarding internal examinations that include fear of allegations of misconduct and lack of confidence (Yanikkerem, Ozdemir, Bingol, Tatar & Karadeniz, 2009:2).

### **Nurses: attitudes and competence**

Participants perceived that the education, counseling and information they received from nursing staff during sexual health consultations lacks important depth. The data demonstrated that some nurses could be experienced as incompetent while some nurses simply overlook the relevancy and importance of providing proper health education and information (see Chapter 4, Section 4.9.2). Attitudes and communication of nurses have an effect on client satisfaction towards nursing care. The communication gap between clients and nurses indicates the need to enhance client satisfaction and ensure quality nursing care (Dzomeku, Ba-Etilayoo, Perekuu & Mantey, 2013:23). Since clients have individual desires and expectations of quality care, this is perceived differently by each individual. Consequently, the assessment of quality care should be based on client perception and satisfaction (Tateke, Woldie & Ololo, 2012:2).

Other data confirmed that participants experienced the staff of CHS as friendly and supportive. Yet there was data that signified that staff could also be judgmental towards students seeking contraception and that such attitudes might discourage students from attending the sexual health clinic (see Chapter 4, Section 4.9.3). The impersonal way in which health care providers sometimes approach clients, often results in discomfort and

shame for the client. Clients often feel they are discriminated against, which has a detrimental effect on their view of sexual health and contraceptive use (Scheppers *et al.*, 2006:343). In addition, uncordial staff attitudes inhibit access to health care services and should be addressed with a view to encouraging and inspiring prompt access to services (Afolabi, Daropale, Irinoye & Adegoke, 2013:822).

#### **Financial issues: affordability of services**

Students who do not belong to a medical aid scheme or the medical aid funds are depleted, are required to settle their account at the CHS. They find the doctor's consultation fee expensive. Furthermore, the underprivileged student who works part-time for extra money and pays for their own studies, experience the fifteen rand cash payment for a urine test as costly. Consequently, financial constraints hinder access to the service. If the clients' account is overdue they are not allowed to consult a doctor (see Chapter 4, Section 4.10). The cost of health services may be the result of clients experiencing difficulty in paying medical bills (Scheppers *et al.*, 2006:341). Financial stress is a leading stressor among students. Consequently, students experience sources of financial stress including unforeseen emergencies and health expenses such as unaffordable medical bills. Therefore, an increasing number of students have to work part time in order to pay for additional expenses such as health care costs (Fosnacht & Dong, 2013:3-4).

#### **Poor administration of accounts**

Poor administration of accounts and the subsequent incorrect billing also cause frustration (see Chapter 4, Section 4.10.6). Such incidents lead to perceptions that the administrative staff responsible for accounts might not be well trained or lack competency. Employees who receive continuous training are more productive and confident; therefore staff education affects client satisfaction. Clients benefit from employees' skills, positive attitude and efficiency (Gesme, Towle & Wiseman, 2010:104).

### **5.2.2 Objective 2: To identify the needs of the clients attending the sexual health service**

#### **Awareness – A need to increase awareness of the clinic**

The current location of the service is explained in chapter 4, section 4.4.5. Several students reflected that the location is far from their residence and that it is off central campus. A need exists to create awareness and provide specific directions to the service as it is unclear and difficult to locate the clinic. If a facility is not available within a short distance it is perceived by

clients to be out of reach. Upon creating awareness of the service, the geographical location of the health care facility should be enhanced (Islam & Aktar, 2011:34).

### **Marketing and advertising: A need to increase marketing and advertising of the service**

The findings indicated that clients are not well informed about CHS and the various services that are rendered. Therefore, a need exists to increase marketing strategies of the facility. Marketing and advertising of the service can be delivered through various sources and channels such as the university's internal radio broadcasts, campus magazine, the university library and intranet web sites (Sing & Begum, 2010:8).

### **Operational hours – Need for after hours and perhaps Saturday services**

Since the findings of the study signified that the operational hours of the clinic clashes with the class schedules of students, a need exists for an after-hours service including Saturday. The literature confirms that access to health care could be influenced by inconvenient and limited operational hours (Majrooh, Hasnain, Akram, Siddiqui, Shah & Memon, 2013: S-65).

Some students reported a need for emergency medical services after hours. These needs are however accommodated by arrangements with the university's protection services. The protection services transport students in need of medical assistance to the nearest public or private hospital depending on whether the student has a medical aid scheme or not (See chapter 4, section 4.6).

### **Waiting periods – Efforts to decrease the waiting periods**

As clients are experiencing lengthy waiting periods (see Chapter 4, Section 4.6.4) a need exists to decrease the waiting period. Client satisfaction is an important outcome that reflects the quality of health care of which patient waiting time is an important component. Health workers should strive to increase patient satisfaction by meeting their expectations and decreasing their total time spent waiting for consultation. Dissatisfaction of clients increases when waiting periods are considered inappropriate and longer than expected. Health workers should strive to increase patient satisfaction by meeting client expectations and decreasing their waiting periods (Ogunfowokan & Mora, 2012:2; Tateke *et al.*, 2012:2).

### **Relationships – A need for scheduled appointments with doctors and nurses with whom the clients feel comfortable**

Clients are seemingly more comfortable with a health care professional with whom they have previously consulted. In addition, it appeared that female participants have gender

preferences regarding with who they would prefer to consult. It was evident that several staff and student participants were not able to consult with the same healthcare professional at each visit. Therefore, a need exists that when appointments are made, the clients are able to decide on a specific doctor or nurse. Consequently, by consulting with the same health care professional or someone of your choice, communication especially regarding sexual health issues could be more comfortable. Continuity of care is affected when a client consults a variety of providers upon each visit (Goudge, Gilson, Russel, Gumede & Mills, 2009:18).

**Finances: support for needy students**

Furthermore, the findings demonstrate that a need exists to address financial expenses that accompany a doctor or specialist consultation for students who do not belong to a medical aid scheme. Literature indicates that there's a general increase in health care costs. Students struggle financially. Moreover, in addition to daily costs of living, students struggle with expensive health care costs. Consequently needy students are in a more difficult position to pay for additional health services (Scheppers *et al.*, 2006: 341; Fosnacht & Dong, 2013:3-4).

**Nurses: health care education**

Several participants verbalized that they require more detailed information regarding their treatment options and interventions from the nursing staff at CHS. They shared that the information that they receive often lacks detail that they require. It therefore seems that the perceived lack of depth in the information provided by the nurses to the clients may be ascribed to the nurses' education, communication abilities or motivation to provide optimal service. Patient education is an essential nursing practice standard, which impacts the clients' health and quality of life. Thus, sufficient education skills and strategies are extremely important in the diagnosis, management and treatment of diseases. Yet, poor education is the most common source of patient complaints. However the inability of staff to educate clients may be attributed to a lack of knowledge and skill level (Aghakani, Nia & Beheshti, 2012:12-15). It is important for health care providers to identify with the clients' needs and expectations. The clients' level of education should be taken into consideration as it is essential for clients to understand what is being explained to them. Often clients are dissatisfied with the information they receive because of ineffective communication skills on the part of the health care provider. This often results in clients misunderstanding information and affects their relationship with health care providers (Fong Ha, Anat & Longnecker, 2010:38-43).



**Nurses: professionalism**

Not all nurses were experienced as friendly and some nurses were perceived to be judgmental towards students purchasing contraceptives (see Chapter 4, Section 4.9.3). The demand for health services is influenced by consumer perceptions and preferences. A barrier to health care exists when clients have disapproving perceptions and attitudes with regard to health services and personnel. Consequently, this may prevent clients from accessing the health service (Scheppers *et al.*, 2006: 340; Afolabi *et al.*, 2013: 822). Therefore a need exists to improve the professional behavior of nurses working at CHS.

**5.3 LIMITATIONS**

The study was conducted at the Campus Health Service of Stellenbosch University. Only permanently employed staff members and students enrolled at the main campus, who had previously used the service, were included in the study. Service delivery at the CHS located on the satellite university campuses was not explored. This is recommended as a future research topic.

**5.4 RECOMMENDATIONS**

Recommendations were made based on the findings of the study. The following recommendations are proposed to improve service delivery and address the needs of the campus community.

**5.4.1 Awareness, marketing and advertising**

Student and staff members revealed that they have been registered and employed by the university for several years, yet only recently became aware of the service. It is therefore recommended that information regarding the service be advertised in the university newspaper, bill boards, university website and buildings that are often visited by students such as the library. An automated advert could also be created on computers of students and staff as advised by Singh and Begum, 2010:8.

**5.4.2 Extended operational hours**

The normal operational hours of the CHS are 08h00-17h00, that often interfere with the class schedules of the students. It is therefore advised that the management of the CHS reconsider the current operational hours. Extended operational hours until perhaps 20h00 or a few hours on a Saturday morning might be beneficial. Operational hours can be construed as a barrier. Therefore, flexible clinic hours would meet the needs and expectations of clients as advised by Scheppers *et al.* (2006:344).

#### **5.4.3 Additional staff members**

It became evident that clients are dissatisfied with the waiting periods at the clinic. An internal inquiry on the length of waiting time of the individual client might be useful to validate their claims. The frequency and length of waiting periods might be useful in determining the precise need for additional staff. A need exists to raise awareness regarding the negative influence of staff shortages on health care interventions. However, this may not change the clients need for care but it could possibly assist to raise awareness of existing shortages as advised by Khalil (2009:42).

#### **5.4.4 Staff development**

It appears that clients expect quality information regarding treatment and management during consultations. Professional competencies have a direct impact on quality care as well as the level of trust the client has in the health professional. The traditional approach to keeping providers up to date is continuing professional development and continuing education conferences (National Department of Health, 2007:16). In addition, the annual performance appraisal should be able to identify their learning needs (Khalil, 2009:442). Continuing education during new employee orientation programs for nurses and periodically thereafter, would assist the nurses in conveying accurate information to clients (Aghakani *et al.*, 2012:6). Consequently, it is recommended that nurses need to be skilled in assessing the requirements and the level of education given to the client.

#### **5.4.5 Standard operating procedures and policies**

Clients should be informed about the reason underlying a consultation for contraceptive pills. In addition, detailed information regarding treatment and intervention should be explained to clients. Consequently clients would understand why purchasing a contraceptive pill from merely a cashier as suggested, would not be possible and realize why a consultation is required.

A variety of reasons for clients not accessing services or treatment is due to a failure of the clinic staff to make a diagnosis, to provide explanations to clients or insufficient effort is made to ensure that the client in fact understands the information provided (Goudge *et al.*, 2009:15). It is recommended that the CHS adhere to the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (Republic of South Africa, 2012:57) that proposes that a consultation is necessary for contraceptive methods, follow up visits and counseling. According to the guidelines mentioned, an initial consultation for contraceptive services should include discussions of previous contraceptive methods, HIV related issues,

lifestyle, risk related issues and history taking. Therefore, the nursing staff should explain the underlying reasons for the consultation to the client.

#### **5.4.6 Consider affordable services**

Since the findings indicate that the services are too costly for needy students, it is advised that the management of the university consider financial aid or strategies to assist needy students with medical expenses. A lack of financial resources or poverty can become a barrier to health care as economic circumstances affect peoples' lives and their ability to seek care and receive care (Scheppers *et al.*, 2006: 340). A key barrier to health care is unaffordable costs. Therefore, low income clients often do not seek care or do so only when they have funds available to access a health service (Goudge *et al.*, 2009:18). In addition, all South African Universities attempt to work in association with the National Student Financial Aid Scheme (NSFAS), which provides financial assistance for underprivileged students (National Student Financial Aid Scheme, 2013:np).

### **5.5 SUMMARY**

It became evident that students and staff members were not aware of the services offered at the CHS, which is a major factor for service attendance. Inadequate marketing and advertising contribute to this factor.

The viewpoint regarding inconvenient operational hours and long waiting periods was prevalent amongst the student participants and accordingly has an impact on their attendance of the clinic, including class schedules.

It appeared that both staff members and students affirmed that it is to their advantage when consulting the same staff when accessing the service and that a staff member of their preference increases their satisfaction.

As cited in chapter 4 clients had different perceptions regarding service delivery at the sexual health clinic. For staff members the service was perceived as excellent, however students reflected that the health information that they receive tends to be rather superficial and inadequate. It is subsequently concluded that staff members at CHS require improved communication skills and that staff development strategies be enhanced. In addition, students were unhappy regarding the financial implications of the service, which according to them is not always affordable.

## **5.6 CONCLUSION**

Considering the findings that various staff members and students were not knowledgeable about the services rendered, it would be useful for CHS to reconsider their marketing and advertising strategies. Yet, for the service to be more effective human resource issues (the possibility of additional staff), the affordability of services and staff development issues should be addressed.

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**APPENDICES**  
**APPENDIX A- SEMI STRUCTURED INTERVIEW GUIDE**  
**RESEARCH INTERVIEW GUIDE**

**TITLE:**

Experiences and perceptions of clients attending a South African University sexual health clinic.

**The interview will be guided by the following open-ended questions:**

1. Tell me about your experiences with the campus sexual health service?

**Probing Words Accessibility:**

Operational hours (waiting times: to see a HCP; for the consultation;

Marketing: (how did you find out about the service: word of mouth, website, flyers, peer)

Location

Financial implication to client

.

**Probing words Service Delivery and Quality:**

Staff approachability, friendliness, attitudes of staff, sympathetic, empathy, concerned, understanding and inquisitive, fairness

Choice of contraception and choice of HCP

Appointment system with HCP

Environmental hygiene: toilets, waiting areas, HCP clothing

Recommend service to others?

**Probing words: Recommendations to Improve Service:**

Can you suggest ways the service can be improved?

More staff, shorter waiting times, broadening the scope of services

Thank you for your time, support and participation.

## **APPENDIX B- PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

### **TITLE OF THE RESEARCH PROJECT:**

EXPERIENCES AND PERCEPTIONS OF CLIENTS ATTENDING A SOUTH AFRICAN  
UNIVERSITY SEXUAL HEALTH CLINIC

**REFERENCE NUMBER:** N09/09/254

**PRINCIPAL INVESTIGATOR:** RUKSHANA ADAMS

**ADDRESS:** 2 NERINA AVENUE, BRANTWOOD, KUILSRIVER

**CONTACT NUMBER:** 073 096 6633

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

The study will be conducted at Campus health Service, University of Stellenbosch.

The researcher aims to have someone not affiliated to the clinic under study to interview a total of 15 participants or will continue until data saturation has been achieved.

The goal of the study is to explore the experiences and perceptions of clients utilizing the sexual health services offered at Stellenbosch University, Campus Health Clinic

The specific objectives are:

- To explore the experiences and perceptions of the clients attending the sexual health service on service delivery.
- To identify the needs of the clients attending the sexual health service.



You have been invited to participate in the study because you are a registered student/staff member at the university who utilize the Campus Health Service

The only responsibility that you have is to answer a few questions during the interview

There is no financial benefit to participants. The results are aimed to improve service delivery at the Campus Health Service.

There are no possible risks involved in the study. No risks have been identified.

Participation is voluntary and we will respect your decision should you decline to participate.

Privacy, confidentiality and anonymity of all participants will be ensured at all times. Confidentiality will be ensured by protecting all data gathered from being made available to any other unauthorized person. Information obtained will not identify the participant personally. Therefore participants will be addressed by aliases during the interviews. In addition, the transcribed interviews will also be nameless and listed according to codes. All written notes and transcripts of the interviews will be kept in a locked safe for five years where after it will be destroyed. Only the researcher, supervisor and co-supervisor will have access to the information. The information will be used in a publication or thesis where participants' identity will remain anonymous.

You will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

**Is there anything else that you should know or do?**

- You can contact Rukshana Adams at 021 808 3496 if you have any further queries or encounter any problems.
- You can contact the **Health Research Ethics Committee** at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent form for your own records.

**Declaration by participant**

By signing below, I ..... agree to take part in a research study entitled *Experiences and perceptions of clients utilizing a South African University sexual health clinic*.



I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*).....on (*date*) ..... 2013.

**Signature of participant      Signature of witness**

#### **Declaration by investigator**

I *Rukshana Adams* ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ...STELLENBOSCH..... on (*date*) ..... 2013.

**Signature of investigator      Signature of witness**

## APPENDIX C – PERMISSION FROM STELLENBOCH UNIVERSITY, CAMPUS HEALTH SERVICE



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kernisvennoot • your knowledge partner

22 January 2013

Institutional Research and Planning  
Stellenbosch University

Dear Prof Botha,

**RE: RESEARCH PROJECT – EXPERIENCES AND PERCEPTIONS OF CLIENTS ACCESSING A  
UNIVERSITY SEXUAL HEALTH CLINIC (N09/09/254)**

I hereby give Rukshana Adams permission to conduct her research project on the abovementioned title at Campus Health Service. The research proposal has full ethical approval.

Yours sincerely

Dr Pierre L. Viviers  
M.Med.Sc; M.B.Ch.B; M.Sc (Sports Medicine)  
Senior Director: Campus Health Services

## APPENDIX D- INSTITUTIONAL PERMISSION, STELLENBOSCH UNIVERSITY



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvenoot • your knowledge partner

15 January 2013

Ms Rukshana Adams  
Campus Health Service  
Stellenbosch University  
7 Claasen Street  
Stellenbosch  
7602

Dear Ms Adams

**Concerning research project: *Experiences and perceptions of clients accessing a university sexual health clinic***

The researcher has institutional permission to solicit clients of the Campus Health Service at Stellenbosch University for their participation in this research project.

This permission is granted on the following conditions:

- the researcher has successfully applied to the Research Ethics Council and has proof of ethical clearance
- the researcher has obtained permission to conduct the research from the Senior Director: Campus Health Service
- clients' participation is voluntary,
- participants may withdraw at any time,
- the researcher obtains the participants full informed consent,
- the anonymity of participants is ensured, and
- the privacy of participants must be respected and protected.

The researcher will act in accordance with Stellenbosch University's principles of research ethics and scientific integrity as stipulated in the *Framework Policy for the Assurance and Promotion of Ethically Accountable Research at Stellenbosch University*.

Best wishes,

Jan Botha  
Senior Director: Institutional Research and Planning



Afdeling Institusionele Navorsing en Beplanning • Institutional Research and Planning Division  
Privaatsak/Private Bag X1 • Stellenbosch • 7602 • Suid-Afrika/South Africa  
Tel. +27 21 808 3967 • Faks/Fax +27 21 808 4533

## APPENDIX E- ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY



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jou kennisvermoot • your knowledge partner

02 November 2012

**MAILED**

Ms R Adams  
Department of Nursing  
2nd Floor, Teaching building  
Stellenbosch University  
Tygerberg campus  
7505

Dear Ms Adams

"The quality of service at a University Campus Health Facility."

**ETHICS REFERENCE NO: N09/09/254**

**RE : PROGRESS REPORT**

At a meeting of the Health Research Ethics Committee that was held on 1 November 2012, the progress report for the abovementioned project has been approved and the study has been granted an extension for a period of one year from this date.

Please remember to submit progress reports in good time for annual renewal in the standard HREC format.

Approval Date: 1 November 2012

Expiry Date: 1 November 2013

Yours faithfully

**MRS MERTRUDE DAVIDS**  
**RESEARCH DEVELOPMENT AND SUPPORT**  
Tel: 021 938 9207 / E-mail: [mertrude@sun.ac.za](mailto:mertrude@sun.ac.za)  
Fax: 021 931 3352

02 November 2012 12:34

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Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



Verbind tot Optimale Gesondheid • Committed to Optimal Health  
Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support  
Postbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa  
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

**APPENDIX F- LETTER OF PERMISSION****CAMPUS HEALTH SERVICE**

Dear Client

A research study will be conducted by Sr R. Adams at the Campus Health Service Clinic during the course of 2013. The proposed study concerns service delivery at the sexual health clinic. Your input would therefore be valuable.

This document merely seeks your permission to be contacted and NOT to actually participate in the study.

It would be appreciated if you would consider completing the document in order for Sr. R. Adams to contact you for possible participation in the study.

Should you consent to be contacted please complete the section below.

I, (Full name and Surname)\_\_\_\_\_ grant permission for Sr R. Adams to contact me telephonically on (mobile Nr)\_\_\_\_\_.

I completely understand that permission is granted to be contacted only and that by signing this document I am not consenting to participate in the research project.

CLIENT:

PRINT NAME:

SIGNATURE:

DATE:

RESEARCHER:

PRINT NAME:

SIGNATURE:

DATE: